Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Amend#2, 23e, PerPhys, PGC10-1-Gertificate of Death 3. Time of Death 2. Date of Death Sept. 19, 2010 1. Decedent's Name (First, Middle, Last) Month 5:02 A M Physician/ AIKENS MELVIN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) PRINCE GEORGE'S **Examiner** CHEVERLY PRINCE GEORGE'S HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1♣ M 2 ☐ F (Month, Day, Year) Days Hours WASHINGTON, DC **Funeral** Months 1942 68 579-56-4845 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f shov 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 😾 Yes 2 🗌 No LANDOVER PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 20785 23a 7835 MICHELE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after death went of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces 1 Never Married 2 X Married 1 Yes 2 XNO BLACK ş 1 Yes 2 XNo Specify Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) nd Mental Hygiene. GOVERNMENT LIBRARY TECH YRS 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ROSA LEE AIKENS ပ္ BENJAMIN JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7835 MICHELE DRIVE LANDOVER, MARYLAND LOIS AIKENS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1
Department of Important: If it any injury or o RESURRECTION CEMETERY 9/29/2010 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Livensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MESTASTATIC LIPOSARCOMA OF THE BACK Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): edical **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CORONARY ARTERY DISEASE or Attending Physician: The law requires that the death certificate be executed l by the attending physician and stacked for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery yes, outcome of pregnancy
Live Birth 2 Fetal death 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Day in the past 12 months? Pregnant at time of death 2 No g 🗌 Unknown been signed by the a should be detached t a 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 X Probably 4 ☐ Unknown TYPE 2 DIBETES 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy HYPERTENSION performed? Yes 2 TXN has page 2 2 No 1 Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 X Inpatient 2 ER/Outpatient 3 DOA ျပ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 5 Pending 1 Yes 2 No s after death.

I Director: After din by the fundament 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a

To the Funeral C

completed filled Hospital Medical 29a. Certifier (Check 29b. Signature and title of certifier INTERNAL MEDICINE PHYSICIAL 9/20/2010 D0063749 MD NVShauth 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 MERTANCILE LANE LARGO, MARYLAND 20772 SHANBRAG M NITA 32. Registra 31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 7/2009

State

SEP 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year MARY REGINA BROOKS A^{M} Medical Sept 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton, MD Union Memorial Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9 / 1 0 / 1 9 3 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Hours Country Director 214-28-338 79 rasonville. MD Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified DE New Castle Newark 1 Yes XXNo 10e. Street and Number ò 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 19713 U.S.A. 48 West Village Road ural", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married 1 Yes If Yes, Give 2X MVo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygier Machine Operator Factory other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Elizabeth Shanks Ernest Burns and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 i 517 Dutch Neck Road, Middletown, Lorraine Cerminara/Daughter item 2 Baltimore, Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 10/1/10 4 ☐ Donation 5 ☐ Other (Specify) Middletown, Hickory Grove Signature of Funeral Service Licenses 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC Broad St., Migg. complications that caused the death. Do not enter the mode of dying, such as cardiac or only one cause on each line. Middletown, 23a. Part 1. Enter the disease, shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ance disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner and Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence oi) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending house and attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) Day Year Pregnant at time of death Unknown n signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Tes Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea. ral Director: After Natural Accident 5 Pending Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29d. Date signed (Month: Day. Year) Theme and address of person who completed cause of death (Item 23a) (Type, Print) SEP 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Inly Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#4perphys9/29/10bbccdolCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. Physician/ 25 2010 Year PM Margaret 12:51 Μ. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Pinetree Assisted Living Bryans Road Charles Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗶 F Months Hours Min. Month, Pay, Year) 10/10/1906 Nanjemoy, 103 MdDirector 578-18-6472 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 1 X Yes 2 No MdCharles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4875 Pisgah-Marbury Road 20658 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 6 t h College (1-4 or 5+) Private Industry Domestic Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nellie Beal Jackson Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4875 Pisgah-Marbury Rd., Marbury, Md 20658 George C. Bowman/Gaurdian Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 9/30/2010 4 Donation 5 Other (Specify) Zion Baptist Ch. Welcome, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bluford Funeral Service Martin Luther King Ave., Wash. DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a cons, quence of) Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Atherosclerotic Cardiovascular Disease that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à The law requires Records, 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform this certificate 2 🗖 No 1 Yes 2 No Physician; Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 DOA 6 ☐ Other (Specify) Nursing hore of To the Funeral Director; After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending Natural Division death. 1 Yes 2 No Investigation 6 Could not be Accident 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29 30. Name and add OX 31. Date filed (Month, Day, Year) State Registrar SEP 29

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ September 25, 2010 12:20A M Bilmanis Erika Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Newburg 12445 Potomac View Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day Year) December 3, 1924 Country) Latvia **Director** 216-58-8636 85 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Newburg 28a-f MD Charles 1 Yes 2X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 20664 USA 12445 Potomac View Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black White etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates "natural" Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Bookeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H marked of ge 1 and 2 should be fil it of Health and Mental : If item 27 is marked မ Zvaigzne Buldurs Kristaps Zvaigzne Marta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8302 Redwood Ct. Jessup, MD 20794Robert Bilmanis/Son 20b. Place of Disposition (Name of cametery, crematory or other place)
Brinsfield-Echols Crem.10/1/2010 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) M01458 21. Signature of Foreral Service Lice ²²AREHAKI CHOUS FUNERAL HOME, P.A. St Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications, that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of dving, such as cardiac or respiratory arrest. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence of): Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami attending physician and for use as the bunal-transit consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Day Vear 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 $\overline{\mathbf{X}}$ Residence 6 \square Other (Specify) 1 ☐ Yes 2 🛛 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Mapner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title of certifier 29d. Date signed (Month, Day, Year) September 27, 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person George Wathen, M.D. 11345 Pembrook Square, Waldorf, MD State 28

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9/22/2010 Lauren Edgar Brubaker, Jr. 2:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10450 Lottsford Rd., Cottage 4207 Mitchellville Prince George's Birthplace (State or Foreign Country)
 Birmingham, AL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Year) 10/8/1914 Days 1 🖾 M 2 🗆 F Hours Min Director 251-60-1775 95 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits the Medical Examiner must be notified at Director 28a-1 1 Yes 2 No MD Prince George's Mitchellville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 10450 Lottsford Rd., Cottage 4207 20721 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 I X Yes 2 ☐ No f Yes, Give ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural" 3 Divorced 4 Divorced Completed White WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. University of Elementary/Seconday (0-12) College (1-4 or 5+) 5+ South Carolina Professor & Chaplain event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even ည Lauren Edgar Brubaker Nora Drake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Barnett-Brubaker / Wife 10450 Lottsford Rd., #4207, Mitchellville, MD 20721 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/27/10 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA RAyRoga Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Fa11 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Subdural Hematoma davs Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events Chronic Subdural hematoma 1 year Due to (or as a consequence of) resulting in death) Last this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the buria Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day 2 🗌 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Coronary Artery Disease, Peripheral Vascular Disease, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Intracerebral hemorrhage, Diabetes Mellitus Type II 24a. Was an performe 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 X Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending 28e. Place of Injury - At home, farm, stri et, factory, office building, etc. (Specify) □ Natural Fell at home 1 Yes 2 No X Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 10 455 5 Latts ford Rond 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12158 Central Avenue, Mitchellville, MD William F. Duboyce, 31. Date filed (Month, Day, Year SEP 2 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of

3

29c. License number

D47603

29d. Date signed (Month, Day, Year)

9/24/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept Month $21^{\,\text{Day}}2010^{\,\text{Year}}$ Physician/ 9:15 A M SHANDELL O. BROWN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George 8507 Osprey Court Ft. Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 26 1965 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 D M 2 X F Days Months Washington DC 44 579-02-2157 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 72 hours after death with the Maryland Director TY Yes 2 No Prince George Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral US 20744 8507 Osprey Court 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give 3 Divorced 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Program Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Antonio Pickens Barbara Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Kenneth Brown - Husband 8507 Osprey Court Ft. Washington Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cheltenham Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Pope Funeral Home 21. Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville Maryland 20747 shock, or heart failure. List of ediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1, Enter the disease Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatic Breast Cancer Physician/ mths. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ or Attending Physician; The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death g Unknown sate has been signed by the page 2 should be detached P.O. 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 횬 1 🗌 Yes 2X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: 24 hours after death. Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No XNatural 5 Pending Accident Investigation the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide determined Hospital filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Karen Smith, M.D. 31. Date filed (Month, Day, Yea

29b. Signature and title of certifier

110 Irving St. N.W. 32. Regintrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Md035950

Washington, D.C.

29d. Date signed (Month, Day, Year, September 24, 2010

20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 26, 2010 Veronica M. Bennett 2:10 aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pine View /Future Care Nursing Home Prince Georges Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days oct. 19 Director Washington, D.C. 579-72-4992 1951 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amount in lyiny or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince Georges Ft. Washington 1 Kes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11911 Aten Street 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐xDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Center Director United Planning Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Floree Sistare Jesse Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyrone W. Cook, Jr. / Son 11911 Aten St. Ft. Washington, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place) Ft. Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 10/1/2010 Brentwood, Md. Algre and Address of Sacility one P.A. 5538 Marlboro Pike/ Forestville, Md. 21. Signature of Funeral Service Lice 101081 Hand 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Hoperation disease or condition Medical Examiner resulting in death) Due to (of as a consequence of): hau Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed ere brovascul Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗷 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending in 24 hours and we have the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature 29d. Date signed (Month. Day, Year)

CE

DHMH 17 Rev 7/2009

State

Registrar

2835 Smith Ave. Suite 203 Baltimore, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dorothy Seay, M.D.

31. Date filed (Month, Day, Year)

SEP 2 9 2010

00053337

September 29, 2010

21209

10-07278 Jacklyn Ann Bass

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Ceres	artment of Health a rtificate of Death	and Menta	l Hygiene	201	0 3300
Physic Medical Exan	ciar nin	1. Decedent's Name (First, Middle,Last) Jacklyn Ann Bass			2. Date of D		3. Time of Death
		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	or Location of D	Septem	Day Year ber 21, 2010	1517 hrs
Funera		Doctor's Hospital 5. Social Security Number 6. Sex 7. Ane (In yes Is	Lanham			Prince Geo	rge's
Directo		5. Social Security Number 6. Sex 7. Age (in yrs. la	Months D			Birth(MM/DD/YYYY) 9.	Birthplace (State or reign Cheverly,
yne		Usual Residence of Decedent	Yrs.		Januar	y 4, 1961	Country) MD
*	١.	Toc. City,	Town or Location				10d. Inside City Limits
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	ceenbelt 10f. Zip Code			40-00	1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	ءً ا	8551 Greenbelt Road, #104	20	0770		10g. Citizen of What C	
r death wi or items must be	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	 13. Was Decedent of F If Yes, specify Cub. 	dispanic Origin?	(Specity Yes or N	lo- 14. Race - Arr	nerican Indian, Black.
after d	A F	Widowed 4 Divorced If Yes, Give Year		lo specify:	Unkno	White, etc	White
2 hours			16a. Decedent's Usual Occup during most of working lif	ation (Give kind	of words also	WII Specify: 16b. Kind of Busines	
036 Athin 7 ene. Ir than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Barber Styl		retired)	Barbers	h a n
15-0 filed v Il Hygie ed othe					me (First, Middle,	Maiden Surname)	
ID 21215-00; should be filed within and Mental Hygiene. 7 is marked other th	To Be	Sau1 Bass 19a. Informant's Name/Relationship (Type, Print)	19h Mailing Address (2)	Melba			(Unav.)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Sandra L. Bass / Daughter	19b. Mailing Address (Stre 686 Loop Roa	d, Fron	r Rural Route Nu. t Royal,	mber, City or Town, Sta VA 22630	ite, Zip Code)
Ore, ges l a t of He : If ite		Removal from State cre	ace of Disposition (Name of ce ematory or other place)	emetery,	Date	20c. Location - City of	or Town, State
Baltimo Permit. Pag Department Important:		4 Donation 5 Other Specify: Met: 21. Signature of Funeral Service Licensee	ropolitan Cremato	- 1	28/2010	Alexandri	a, Virginia
Balt permit Depart Impor injury		H tonstand land	22. Name and Addres	norol H	nme PA		more Avenue Le, MD 20781
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Defailure. List only one cause on each line.	o not enter the mode of dying,	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval
Examiner	H	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of):					Between Onset and Death
	'n	Sequentially list conditions, b					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated					
uted 1d ransit		events resulting in death) Last					-
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and functed director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED					-
8760, tiffcate be ng physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the	су			23d. Date of deliver	<u></u>
Box 687. he death certifing the attending the for use as the	/sician/	past 12 months? 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 5 Other (Specify)	Ectopic pregn	ancy		Day Year
D. B.	21	Part II. Other significant conditions contributing to death but not result					
s, P.O.			ting in the underlying cause gi	iven in Part I.		pacco use contribute to	
Division of Vital Records, tale or Attending Physician: The law require and a fair death. In Director: After this certificate has been sied in by the funeral director, page 2 should be a fair.	Completed				24a. Was ar	n 24b. Were au	topsy findings available
tal Rec					autops perforn 1 Yes 2	prior to c death?	completion of cause of
Vital ysician his certi director	ן מב	25. Was case referred to medical examiner? Hospital: Inpution 2 50		of Death (Check	only one)		s 2 No
n of V	2	27. Manner of Death 28a, Date of Injury 28b	Outpatient 3 DOA DO. Time of Injury 28c. Injury		g Home 5 R		
Sion Attend death. ector:		Natural 5 Pending FOUND: Day, Year)			Subject shot	w injury occurred	1
Divi	- 1	Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office bui	ilding, etc.	28f. Location (Str	eet and Number or Rur	al Route Number, City
Division To the Hospital or Attenwithin 24 hours after death within 24 hours after death completely filled in by the	2 2 E	4 Homicide determined (Specify) Multi-Family A 9a. Certifier 1 Certifying Physician: To the best of my knowledge, de nee) 2 Medical Examiner: On the basis of examination and/or		Į.	3551 Greenbelt	Road Lanham MD	
To the within To the comple		and manner stated	investigation, in my opinion, o	and place, and death occurred at	due to the cause(the time, date an	s) and manner as stated d place, and due to the	d cause(s)
	2	9b. Signature and title of certifier	29c. License r	number		29d. Date signed (Mont	
,	3	0. Name and address of person who shall leted cause of death (Item 23a)	O.C.M.	.E. 		September 22, 20	10
2	Ĺ.	Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, B	altimore, MD	21201		
Stat Registra	e 3 r	SEP 2 9 2010 SEP 2 9 2010 SEP 2 9 2010 September 32. Registrar's Signature	1				
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		01					

DHMH 17 Re OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>2</u>010 3:20 Banz September Betty Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Solomons Solomons Nursing Center If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🖾 F Days North Carolina Months Hours (Month, Day, Year) Director 213-34-1713 85 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛱 No Lusby Maryland Calvert 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 20657 11600 Big Bear Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: If Yes, Give Year or Dates Specify: White 3 ⅓Widowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If frem 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools School Bus Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ <u>Mason L. Per</u>kins Mattie Lee Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11600 Big Bear Lane, Lusby, MD 20657 Clara Jewel Beatty/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metropolitan Crematory 10/01/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, T.A. Signature of Funeral Service Licensee Thechael P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA Physician/ marty disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner years HTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 monthe? Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ CANCER () KIDNEY 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, CAD, CKD, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? DEPRESSION 24a. Was an autopsy performed? Jas 1 ☐ Yes 2 ☐ No certificate Yes 2 TNo 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other: 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Quertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number September 27, 2010 D36969 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar
DHMH 17 Rev 7/2009

State

Scaria Mathew, MD
31. Date filed (Month, Day, Year)

SEP 27 2010

parks

32. Registrar's Signature

11910 H.G. Trueman Road, Lusby, MD 20657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ REGINA Month Medical 2010 6:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AMNAPOLIS MEDICAL CENTER ARUNDEL ANNE Social Security Number **Funeral** 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 216-76-8160 8. Date of Birth Birthplace (State or Foreign Country) 1 - M 2 X F Director Months Min. Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County **Funeral Director** 10a. State 10c. City, Town or Location 10d. Inside City Limits MDCalvert Chesapeake Beach 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4155 Bristol Drive 20732 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 Black, White, etc. Completed 3 Divorced 4 Divorced 1 ☐ Yes 2 X No Specify. White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Division Administrator Federal Reserve Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Breen Marie McCloskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Emily Nix/Sister 21815 New Hampshire Ave, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lincoln Cemetery 09/30/2010 Brentwood, 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Lee Funeral Home (8125 Southern Md Blvd., Owings MD) Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ METASTATIC GASTRIC CANCER **∦**Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last physician a the burial-1 Due to (or as a consequence of): by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Director: After this certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ٥ 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 1 Natural 2 Accider 28d. Describe how injury occurred 5 Pending (Month, Day, Year) work? Investigation
6 Could not be Accident 2 No Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State, 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the P 29b. Signature and title of g son who completed cause of death (Item 23a) (Type, Print)

State Registrar

			Amend #30 per DVR	Type or Print in	Black Indelib	le Ink. Ensure A	All Copies Are	e Legible.				
			1 - For State Registrar	State of Maryla	State of Maryland / Department of Health and Mental Hygierie 3 2 0							
			Registrar 1. Decedent's Name (First, Middle, L	actl	Certifica	ile oi Dealii	Reg. t	No.	3. Time of Death			
	Physici		A A A A A A A A A A A A A A A A A A A		Soisseau	_		Day Year	(,500 W			
	/Medic		4a. Facility Name (If not institution, gi	-		y, Town, or Location of Deat		4c. County of Death	CALVERTCO			
	Examin Funeral	lei	CALVERT MEMOR 5. Social Security Number 6.	AL HOSPITAL	PR rs. last birthday) If Unc	NCE FREDER	8. Date of Birth (Month, Day, Yea	Pence France France France Pence France France Pence France Franc	ederick place (State or Foreign ntry)			
	Director		227 - 16 - 35 35 Usual Residence of Decedent	7	Yrs.		DEC. 15,1	1918 VIR	GINIA			
	Maryland f ehow	tor	10a. State 10b. County	100.	City, Town or Location	AIC		1	10d. Inside City Limits 1 ✓ Yes 2 □ No			
	r 28a	Irec	10e. Street and Number	1		Zip Code	10g.	Citizen of What Cour	ntry?			
	th with	alD	11750 ASBU	er likele		20688		USA				
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Ifem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wedicul Expirit arrival te trauffical	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puen 2000 Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: W1-				
5-0036	2 hou	ted	15. Decedent's 1	Education	16a. Decedent's U	sual Occupation	16b.	Kind of Business/In				
21218	filed within 7 Hygiene. other than "n ent, the Med	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	1 f	work done during most of wo use retired)		tomemo	Ken			
pul	be file ital Hy id oth svent	Be	17. Father's Name (First, Middle, Las	3		18. Mother's Nar	me (First, Middle, Maio	den Sumame))			
Maryland	hould be d Mental narked o	2	19a, Informant's Name/Relationship	Clif TON	WCKER_	ess (Street and Number or R	Wal Route Number Cit	ty or Town State Zin	OWELL			
Ma	id 2 sho ith and 27 is mu traum		1) R	To dito	994 W/=	C 1/11. (- 11 a.	ando FL	34442			
ē,	pernit. Pages 1 and Department of Health Important: If item 27 any njury or other to once.	1 3	20a. Method of Disposition	1 Jangha 20th	p. Place of Disposition (f	lame of			own, State			
Baltimore	Pages nent of int: If it	113	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		TT NEW Bring	och the tem 1	0/2/2010 M	CKENNEY	.VA			
alti	permit. Pag Department Important: any njury o		2) Signature of Funeral Pervice Lice	14 110 -	22 Name	and Address of Facility	11	1/2 /// 2/	OLI VA			
ä	Department of the partment of		pomille	mule	Joseph	McMiniANtu	meral Home	POBOX 130	Blackstone 2362			
			23a. Parti Enter he disease, or co shook, or heart failure. List onl	nplications that caused the de y one cause on each ine.	eath. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,	'	Approximate Interval Between			
А	Physician		Immediate Cause (Final disease or condition	Preum	one				Onset and Death			
т	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			4			
н	_xummer	_	Sequentially list conditions.	b. Due to for as a cons	souppos offi				CIAS			
	ted nslt	nlne	cause. Enter Underlying Cause (Disease or injury	Control of the state of the	ectionis sty				,			
	certificate be executed Iding physician and Ise as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons	sequence of):							
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687	ifficati g phy as the	edic	-									
P.O. Box	law requires that the death certificate be exast been signed by the attending physician 2 should be deteched for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 □Ectopic			23d. Date of deliv Month	rery Day Year			
	that the photograph of the pho	y Ph	Part II. Other significant conditions	contributing to death but not	resulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?			
Records,	quires n slg/ uld be	Completed by	Acerte van	I Contine	conjecto	re less	1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown			
00	aw require s been sly 2 should b	olete	Pailure	COPI	0		24a. Was an	24b. Were aut	opsy findings available			
R	The la ate ha	E					autopsy performed 1 ☐ Yes 2 🗷	? death?	ompletion of cause of			
Vital	lan: rtifica ctor. p	Be C	25. Was case referred to medical examiner?			26. Place of De	ath Check only one					
of V	hysic his ce I dire	To	1 ☐ Yes 2 No	Annual Control of the		DOA Other: 4 Nursing I	Home 5 Residence	e 6 ☐Other (Speci	ify)			
n	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year		28c. Injury at Work?	28d. Describe how in	njury occurred				
Division	or Attending Physician: after death. Director: After this certifics in by the funeral director. I	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury - A	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
J	To the Hospital or Attending Physiclan: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce		Physician: To the best of my laminer: On the basis of exam and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier) / [7	29c. License number	29d.	Date signed (Month	. Day, Year)			
	->-0		1	7	2,00	D006178	3	9/25/2	5110			
			30. Name and address of person wh	o co a leted cause of death (I	tem 23a) (Type, Print)			//-				
			Chang Bae Choi,			ince Frederic	ck, MD 2067	78				
7	Sta Registi		31. Date filed (Month, Day, Year)	2. Registrar's Signature	grature parks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Edna H. Brown 2010 1000 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing_Home <u>Pocomoke City</u> Worcester **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2**X** F Days Year) 1919 Hours **Director** 229-09-5036 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director notified a 28a-f 1 X Yes 2 No MD Worcester Pocomoke City 10e. Street and Number items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 3707 Brantley Road 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. SpeciBlack Completed 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Vernon Drewer Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Clam Co other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F Department of Health and Ments Important: If item 27 is marked any injury or other treasures. မ Thomas Copes Elizabeth Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie Collins/Daughter 3707 Brantley Road, Pocomoke City, MD 21851 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Μt Sinai Bapt Cem 10-2-2010 Pocomoke, MD 21. Signature of Funeral Service Licensee Bennie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the sease, or complications that caused shock, the art failure. List only one cause on each line. Immediate Cause (Final disse or condition resulting in death)

a. Due to (or as a sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death LUNG Physician/ CARCINOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or) nding physician and use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a d be detached f 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law cate has page 2 s autopsy performed? Yes 2 death? 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No ပ Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work' 124 hours after death. le Funeral Director: Al pleted filled in by the fu 1 Yes 2 🗆 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted To the within 2 29b. Signature and title of certifer 29d. Date signed (Month, Day, Year) 00062172 9/23/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1604 MARKET ST. POLOMOKE CITY MD SATYAL. MD 31. Date filed (Month, Dav. Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Fegistrar's Signature

SEP 2 R 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marion September 2010 Bennett 9:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15301 Pine Orchard Drive Apt 2C Silver Spring Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 17, 1919 **Funeral** 9. Birthplace (State or Foreign Days 1 M 2X F Hours England Director 219-58-8039 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 15301 Pine Orchard Drive Apt 2C 20906 United States or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3

Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be filed hand Mental H 7 is marked of ည James Harold Wardle traumatic Ethyl Coombs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Adele M. Leach/daughter P.O. Box 526 Falls Church, Virginia 22040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite cemetery, crematory or other place ö 1 Burial 2 X Cremation 3 Removal from State injury (4 Donation 5 Other (Specify) Journey Crematory 9/27/2010 Woodbine, Maryland ture of Funeral Service Lice Golffe Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 any M00957 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiac Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Day signed by the at be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Tes 2 No 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Failure To Thrive autopsy performed? page certificate 1 Yes 2 No 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home X Residence 6 Other (Specify) 1 Yes 2 **X**No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tang 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 17904 Ata Motamedi, M.DGeorgia Avenue, Suite 304 Olney, Maryland 20832

DHMH 17 Rev 7/2009

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

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		For State	State of		d / Depa	artme		ealth and	-	giene		32011
Physicia	in/	1. Decedent's Name (First, Mic				unca	e or D	Catri	2. Date of De Month	Day	7 2010	3. Time of Death
Medic Examin		James R. 4a. Facility Name (if not institut	Beerbower tion, give street and number	er)		4b. City	, Town, or	Location of Death	Septem	4c. C	7, 2010 ounty of Death	1:45 A ^M
		Manor Care I				1	Poto		1		Montgom	
Funeral Director		5. Social Security Number 159-30-7161 Usual Residence of Decedent	6. Sex 1 X M 2 F	. Age (In yrs. Ia	ast birthday) Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Apr 5,	1927	9. Birthp Coun Ind	place (State or Foreigr ntry) 1ana
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. Cour	10c. Cit		Town or Location						10d. Inside City Limits	
	Öğ	10e. Street and Number			VV		ngton p Code			10g. Citize	. Citizen of What Country?	
s 23a	eral	550 N Street	t, SW, #S102				2002	4		Uni	ited Sta	ates
s after death al", or items Examiner m	þ	11. Marital Status 1 Never Married 2 X 3 Widowed 4 Divorce	If Yes Give	es?		If Yes, spe	dent of His cify Cubar 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		. Race - Americ Black, White, becify: Whi	etc.
in 72 hours e. nan "natur e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5			16a. Deced	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						dustry
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oe file intal H ced of c ever	10 B	17. Father's Name (First, Middl Walter Bee	erbower				İ	18. Mother's Nar		, Maiden Sui ndersc	-	
nd Me s marl		19a. Informant's Name/Relation			19b. Mailir	ng Addres	s (Street a	nd Number or Ru				Code)
id 2 sh salth a n 27 is er trai		Barbara Frie	edman/wife			_		SW #S10				
age 1 an ent of He nt: If iten y or oth	-	20a. Method of Disposition 1 ☐ Burial 2 【XCremati 4 ☐ Donation 5 ☐ Othe	ion 3 Removal from St	tate c	Place of Disponentery, crer	matory or	other place		Date	l	ation - City or To	own, State Maryland
permit. F Departm Importal any injul		21. Signature of Funeral Service		<u> </u>				s Cremati				
8 8 E 8 8		Juanta (*	Thomas	MOO	957 B	ever.	ly L.	Heckrot	te, P.A	. Clai	rksville	e, MD 2102
Physician/ Medical Examiner												Approximate Interval Between Onset and Death
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or Attending Physician: The law requires that the death certificate after death. after death. Director, After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		rth 2 🗌 Feta ant at time of c	ıl death 3	☐ Ectopic ☐ Other (s	pregnancy pecify)	1	<u>.</u>	23	d. Date of delive	ery Day Year
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sician: The law requires the certificate has been signe irector, page 2 should be to	Completed by								24a. Was auto perfi 1 Yes		24b. Were auto prior to co death? 1 ☐ Yes	psy findings available impletion of cause of
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Attending Physic If death. Sector: After this ce by the funeral dire	2	1 ☐ Yes 2X No 27. Manner of Death	1 ☐ In	patient 2 injury	ER/Outpatier 28b. Time of		Other 28c. Injury	4 Mursing H	lome 5 Resi			2
nding tth. : After s fune	cate	1 Natural 5 ☐ Per		Day, Year)	injury	м	work?		20d. Describe	now injury o	ccurred	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	al Certificate:	3 Suicide 6 Cou	uld not be 28e. Place of	f Injury - At ho , etc. (Specify		reet, factor	y, office		28f. Location (City or To		lumber or Rural	l Route Number,
the Hosp nin 24 hou the Funer	Medical	(Check 2 Medica only one) 3 Certify	ring Physician: To the bes al Examiner: On the basis ring Nurse Practioner: To	of examination	and/or inves	tigation, in	my opinior	n, death occurred	at the time, date	and place, ar	nd due to the ca	use(s) and manner state
To Vitt		29b. Signature and title of certi				29	c. License	number		29d. Date s	signed (Month, I	Day, Year)
			s Masters				D50	0534		Septe	ember 27	7, 2010
<i>t</i>		30. Name and address of personal address of pe						1	N/T			221.01
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 23:03 PM Harry Royston 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death arroll JOSTMINSTER Carrol Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** N 2 □ F Days Min. 212-36-6223 Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** 28a-f Marvland Carroll 1 ¥ Yes 2 ☐ No Manchester è 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2841 Chauncey Hill Drive 21102 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. or. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced Specify: white Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur ther traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver overland transport Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry R. Bargar, Sr. Thelma R. Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole J. L. Bargar - wife 2841 Chauncey Hill Drive Manchester, MD 21102 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Sept. 21, 4 Donation 5 Other (Specify) Millers U.M. Cemetery Millers, Maryland 21. Signature of Funeral Service Licen, ed 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hrs cong Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Month Year Day Pregnant at time of death cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 g 9 ☐ Unknown 9 I Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Tes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner's é Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29d. Date_signed (Month, Day, Year) Britos 0064732 NI 10 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) Martin Britos-Bray, M.D. 200 Memorial Ave. WEstminster, MD 21157

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 6, Physician/ 4:05 p William Balant 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll **Examiner** Carroll Hospice Dove House Westminster 8. Date of Birth Sep 22, 1925 Social Security Number 6. Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Months Days Hours 84 061-20-1359 Pennsylvania Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster Carroll 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21157 1225 Beggs Road USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white WWII 3 ¥ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Susan Trochcza Steve Balant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 South Eads, apt 1120, Arlington, VA 22202 it of Health a Susan French Balant, daughter init, Page 1 an.
Department of He
Important: If P
any injury Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of occupant) of Property of Other place) 20c. Location - City or Town, State Date 1
Burial 2 Cremation 3 Removal from State 9/17/2010 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Side ature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final five days Physician/ aspiration pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, right cerebrovascular accident-2004 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 2 🗆 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospita or Attending 24 hours after death. 1 🛚 Natural 5 Pending 1 🗌 Yes 2 🗌 No neral Director A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WSL 8 TIVA

Box 68760

P.O.

29b. Signature and title of certifier

Howard G. Lanham,

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ms

215

D17040

Washington Heights Medical Center

Westminster, MD 21157

29d, Date signed (Month, Day, Year)

2010

September 17,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Mai		artment of Hear Intificate of Dea			ene g. No.2010	32017			
1. Decedent's Name (First, Middle Physician/				Last)		RYP	ALE	2. Date of Death Month 9/19	1	3. Time of Death			
	Medic	al	4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or Lo	cation of Death	9/19	4c. County of Dear				
660 Chapel Gate Drive						Oden	ton f Under 24 Hrs.	(5)		rundel			
	Funeral Director		5. Social Security Number 080-30-1534	6. Sex 7, Age ((In yrs. last birthday) 73 Yrs.		Hours Min.	8. Date of Birth (Month, Day, 18/22/1	year) 9. Bir 937	thplace (State or Foreign untry) NY			
	nd ihow at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits			
	Maryla 28a-f s otified	irect	MD Anne	Arundel		Odenton	n 1 □ Yes x 🛭 No						
	ith the	ralD	10e. Street and Number	Drivo		10f. Zip Code	21113	10	ng. Citizen of What Co USA	ountry?			
	eath w tems 2 er mus	Funeral Director	660 Chapel Gate 11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe	cify Yes or No-	14. Race - Ame				
36	be filed within 72 hours after death with the Maryland ental hygiene. ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at	þ	1 Never Married 2XXMarri 3 Widowed 4 Divorced	Armed Forces? ed 1 Yes 2 N If Yes, Give Year or Dates.	0	_	Specify:	ncan, etc.)	Black, Whit Specify:	e, etc. White			
2	hours natura dical E	Completed		t's Education		dent's Usual Occupatio kind of work done durir		70	16b. Kind of Business	Industry			
121	ithin 72 ene. r than	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)) life. D	ONOT use retired) Id Cashier	ng meet er wemi		Pharmacy	,			
Maryland 21215-0036	filed w al Hygi d other	Be	17. Father's Name (First, Middle, La	ıst)	UNK 18. Mother's Name (First, Middle, Mail								
r <u>yla</u>	ould be d Ment marke matic	욘	19a. Informant's Name/Relationsh	Estelle Se (Type, Print) 19b. Mailing Address (Street and Number or Rural Route									
	s 1 and 2 should be file of Health and Mental F if item 27 is marked o' r other traumatic ever		Joseph A. Byrne	Spouse		Chapel Gat			-				
ore,	Page 1 an nent of He ant: If iter ury or othe		20a. Method of Disposition 1 → Burial 2 → Cremation	3 ☐ Removal from State	20b. Place of Dispo			Date 2	20c. Location - City or	Town, State			
Baltımore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service Li			Cemetery Name and Address of			Rockville,				
Ball Annapo								olis Rd. Gambrills, MD 21054					
	40.00		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death disease or condition										
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	ONITK	101	MDC	L()				
	Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence oi).										
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c	0	OBESITY							
	certificate be executed anding physician and use as the burial-transit	al Ey	resulting in death) Last	Due to (or as a d	consequence of):		,						
3760	ficate b g physias the b	Medical	IS SENAN S	d									
Box 68	ath certi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de	livery Day Year			
Ö.	the dea by the a ached f	hysic	1 Yes 2 No 9 Unknown	9 🗌 Unknown									
P.O.	es that signed b	by	Part II. Other significant conditio	ns contributing to death but	not resulting in the o	underlying cause given	in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown					
ords	requir been s	letec	COPD	1470	ERT	ENSI	ON	24a. Was an	24b. Were au	itopsy findings available			
Vital Records,	The lav ate has page 2	Completed	/					autopsy perform	ed? death?	completion of cause of			
'Ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	4 0 T 5D/O 4 4 4	_ Other:	of Death (Check	1		· · ·			
01	ng Phy ter this neral d	ite: To	27. Manner of Death	28a. Date of injury				28d. Describe how	nce 6 Other (Spec v injury occurred	ciry)			
DIVISION OF	vttendii death. ctor: Ai y the fu	Certificate:	2 Accident Investig	ation ot be	/ - At home, farm, sti		s 2 No	28f Location (Str	eet and Number or Ru	ural Route Number.			
Š	tal or / irs after al Dire led in b		4 ☐ Homicide determi	ned building, etc.				City or Town,					
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical E	Physician: To the best of m caminer: On the basis of exa Nurse Practioner: To the be	amination and/or inves	stigation, in my opinion, o	death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.			
	To the Comp	2	29b. Signature and title of certifier			29c. License nu			od. Date signed (Mont				
			30. Name and address of person v	the completed course of day	ath (Item 23a) (Time		631	45	112	0/10			
H	+4		ARVIND	DESA	1 70	5 DIC	ITA	-LDR	LIN	THICUN			
	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 2	2010 32. Régistrar	s Signature	back							

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9/20/2010 Physician/ 7:03am M Ann Bridges Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Atlantic General Hospital Worcestor Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 141-34-9008 Months Hours Min. 3777977943 NY Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 28a-f shor 10a. State 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at death with the Maryland Director 1 ☐ Yes 2XXXNo Annapolis Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral USA 21403 109 Great Lake Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc.
White Armed Forces? 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Labor Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Mclaen Hugh Feeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3/19/43 109 Great Lake Dr. Annapolis, MD 21403 Husband Gaylon Bridges 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2√ Cremation 3 ☐ Removal from State 9/22/2010 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fun Service Licensee Annapolis, MD 21401 Jaw 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ complete disease or condition resulting in death) Medical Examiner rdiomyo Sequentially list conditions, Examine cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 moviths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ₩ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to edical Vital 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury 28b. Time of 3ndges, Ann Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Durkin 9733 Hez// Hez/ Thuis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07:03

100

9 20 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygiene	10 32019				
			116glottal	rtificate of Death	Reg. No.	10 02017				
Pi	hysicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 09-18-2010	3. Time of Death				
	Medic	al	Modupe Omolara Busari-Blaken			12:32 p ^M				
) E	Examin	er	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4c. County of Montgo					
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		Birthplace (State or Foreign				
	uneral rector		217-73-6419 1 M 2 X F 41 Yrs.	Months Days Hours Min.	03-18-1969	Nigeria				
	M.	ij	Usual Residence of Decedent							
/land	f sho	ķ	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits				
Mar	28a- notifie	ie	MD Prince George Fort Was			1X Yes 2 □ No				
th the	3a or	Je.	10e. Street and Number	10f. Zip Code 20744	10g. Citizen of W					
ath wi	ms 2 mus	Funeral Director	7309 Lanham Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13.		Nigeria	- American Indian,				
o de	or ite niner	by Fi	1 X Never Married 2 Married 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		r, White, etc.				
933	raľ", Exar		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:	Specify:	B la ck				
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antal I	ked c	입	Murphy Onioniyi Busari		o Aribike Odumo					
S Divoid	s mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Rura	al Route Number, City or Town, St	ate, Zip Code)				
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.	n 27 is er tra		Tenitope Akimpetide (Sister) 7309	Lanham Ln. Fort W	ashington, Mary	land 20744				
of Fe	r oth	- [20a. Method of Disposition 1	osition (Name of matory or other place)	Date 20c. Location -	City or Town, State				
Page 1	ant: I		4 Donation 5 Other (Specify) Heritage C	emetery Dct.		f, Maryland				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	Important: If any injury or once.			2. Name and Address of Facility $W.H.$						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between				
∼ h s	sician/		Immediate Cause (Final Branch Cancer Onget							
M	edical	resulting in death) Due to (or as a consequence of):								
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certifica	anding use a	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy	23d. Date	e of delivery				
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e law	8 01	Completed			autopsy p	rior to completion of cause of eath?				
~	certificate ha irector, page 2		25. Was case referred to medical	26. Place of Death (Checa		Yes 2 No				
Vita /sicia	s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	- Other:	ome 5 Residence 6 Other	r (Specify)				
ot ^{Ig} Ph	ter thi		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury	,	28d. Describe how injury occurre					
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death.	filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place. ar	nd due to the cause(s) and manne	r as stated.				
n 24 h	e Fur	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inversionly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred a	t the time, date and place, and due	to the cause(s) and manner stated.				
¥. ق	₽ 👨		29b. Signature and tip of cartifier	29c. License number	29d. Date signed	(Month, Day, Year)				
3	3		e williams	D54378	09-18-1	.0				
			30. Name and address of person who completed cause of death (territon) (Type, 2730 University Blvd #400 Wheaton, M		worth, M.D.					
	Stat	e	31. Date filed (Month, Day, Year) 31. Registrar's Signature	4.1	5.4					
F	Registra		31. Date filed (Month, Day, Year) SEP 27 2010 31. Registrar's Signature							

State Registrar

DHMH 17 Rev 1/2001

SEP \$7 2010

Susan J. Miller,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

8218 Wisconsin Avenue. #305. Bethesda. Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 20, 2010 **Physician** Stoll Lookerly 2355 PM Ernest /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent Center hestertown hester River Hospi tal If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□F Months Days Hours 215 10 9739 93 SEPTEMBER 10,1917 Director MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at KENT 1 Yes 2 □ No CHESTERTOWN MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number LEARMAN 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Wes 2 No. 151-53 If Yes, Give Year or Dates: 1941-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 5 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) TURNEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be COCKERL-ERNEST HRISTINE STOLL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health ant: If item 27 is KICHARD NECK LANDING ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 9/22/2010 4 ☐ Donation 5 ☐ Other (Specify) CHESTER M00625 21. Signature of Funeral Service Licensee IAM, JR FUNERL DIRECTOR 205 GREEN HERON WAY 130 SPEER RD. CHEST GATEL 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi): ending physician and use as the burial-transi Due to (or as a consequence of): Box 68760 þ Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 → NO 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☑ No ospital or Attending Physician: hours after death. After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after dean.

To the Funeral Director: After the full part of the full part 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lestatoon Md. 21620 tox Washing 1635 32. Registrar's Signature 31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cook Sept Phillip. Daniel 2010 4:00 AM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Cheverly Prince Georges Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 12, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Hours Md. 63 Director 217-46-6913 1946 Dec. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Seat Pleasant Prince Georges Md 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò or than "natural", or items 23a of the Medical Examiner must be Funeral 6408 Adak Street 20743 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other thi any injury or other traumatic event, the lonce. Local Government Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alice Jones Erwin Cook Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Mills/Daughter 20746 5168 Clacton Ave., Suitland, Md 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Wash. National Cem 10/1/10 Suitland, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bluford Funeral Service 21. Signature of Funeral Service Licenses 2019 Martin Luther King Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death detached the 9 Unknown 9 Unknown ģ cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 ¥ Yes 2 □ No 3 □ Probably 4 □ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🔀 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner, on the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse P within 2 29b. Signature and title of certified

Registrar

DHMH 17 Rev 7/2009

State

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Tin Tai Chang September 22, 2010 Year 5:25 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suitland 4903 Procopio Drive Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕁 F Months Days Min. Oct 21. 1925 Fuzhuo, China **Director** 84 577 76 0293 Usual Residence of Decedent 28a-f shov 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes XX No Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4903 Procopio Drive 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ò 1 Never Married 2 X Married Yes, Give Baltimore, Maryland 21215-0036 2 XXNo 1 Yes 2XX No Specify: Completed Specify: Oriental 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 8th College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) should be filed hand Mental H 7 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Cheng unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Kun Chang (son) 4903 Procopio Drive, Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Oct 5. 2010 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Road, Clinton, MD 20735 23a. Urt 1. Enter the we ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a surrequence oi). and I-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 I Inknown P.0. signed by to detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 🗀 Yes Yes 2X No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural n 24 hours after death.

e Funeral Director: After the function is the function of the function is the function in the functio 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature itle of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, AMANAN DAD 1501 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 22 2010 10:45 P M CONTEH JOSEPHINE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. SEPT. Day 29 ar) 1950 Hours 1 M 2 X F STERRA LEONE 59 Yrs. Director 577-39-4970 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S MD HYATTSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 2010 DREXEL STREET # 304 20783 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event." (Specify only highest grade completed) Elementary/Seconday (0-12) 12TH College (1-4 or 5+) PRIVATE RESIDENTIAL COUNSELOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CONTEH MANIO CONTEH YARABA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALIFU CONTEH - HUSBAND 7018 DOLPHIN ROAD LANHAM, MARYLAND 20706 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 10/9/10 SILVER SPRING, MARYLAND 22. Name and Address of Facility 21. Signature of Juneral Service Licensee J. B. JENKINS FUNERAL, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Pay . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ASCVD Medical Due to (or as a consequence of): Examiner CHRONIC RENAL FAILURE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit SEPSIS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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Records, **Division of Vital** Hospital or Attending 24 hours within 2 To the

Box 68760

P.O.

State Registrar (Check

only one) 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

SPORN, M. D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

otenber 22,2010

29c. License number D58461

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti. MD Assistant Medical Examiner

2010

31. Date filed (Month, Day Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ Russell Larry Crandell 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Nicomico Hos Loasta Salisbury If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 D F **Funeral** 65 07/19/1945 215-44-0127 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Me-it-al Examiner must be notified. 1 X Yes 2 No Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12907 Pine St., Apt. A-1 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify: If Yes, Give Year or Dates white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) carpenter construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edgar Willis Crandell Emma Lou Ferrier 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12907 Pine St. apt. A-1, Ocean City, MD 21842 Dawn Crandell/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🗷 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 9 27 2010 Hanover, MD 21. Signature of Funeral Service Licensee Horioway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GASTRIC CARIGNOM disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 124 hours after death.
• Funeral Director: After this certificate has b. autopsy 28 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \sum Yes 2 🗌 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hurgm 2 BOP

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP

28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 32027 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 9:00 A M Eleanor September Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sanctuary at Holy Cross Burtonsville Montgomery 8. Date of Birth Date of billing (Month, Day, Year) 5 1938 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 F Months Hours Min. Director England 158-44-7684 Aug 6, an "natural", or items 23a or 28a-f show Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked than than "natural", or items 23a or 28a-f sho ramatic event, the Medical Examinar must be notified at ramantic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 Club House Road 20886 United States 12. Was Decedent Ever in U.S. Armed Forces?
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Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/24/2010 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licenses anita M00957 Beverly L. Heckrotte, P.A. Clarksville 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ melastatu Cancer to brain, Spine, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown g Unknown P.0. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed⁴ certificate 2 🗌 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 1No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 300W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 283 Pegistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 26, Physician/ 2010 11:25A M Cutcher Noralee Jean Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 9300 Gue Road Damascus 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Year) 1921 1 □ M 2 🔀 F Months Days Hours sept 20, Kentucky 89 237-28-1740 **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No Maryland Montgomery Damascus ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 9300 Gue Road 20872 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify. Completed 3 Wildowed 4 Divorced White nd Mental Hygiene. s marked other than "natura umatic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F is marked o 2 Ollie Cronin Russell James Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Patricia Jean D. Wilson/daughter 9300 Gue Road Damascus, Maryland 20872 tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/29/2010 Woodbine, Maryland 21. Sign Iture of Funeral Service Going Home Cremation Service P.O. Box 784
Beverly 1. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoul, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph sician/ byears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (ur as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year ed by the g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be det þ reseprovascular acciden 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 X No 1 Tyes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

5

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

only one 29b. Signature and title of certifi

one and address of person who

Senlamin T. 31. Date filed (Month, Day, Year) SEP 28

tapoi

32. Registrar's Signature

MARIAN -

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H58132

sompleted cause of death (Item 23a) (Type, Print)
apoi D.O. 9815 Main Street, Suite 248, Domascus MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Ammended box #18 Per F.H. WSH Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ 3:20 P^M Robert Carroll Colson, Sr. Sept. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Westminster 1913 Frizzellburg Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral (Month, Day, Year) Months Days Hours Min 1 🔀 M 2 🗆 F Director 212-38-1895 Feb. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Tyes 2 No Westminster Carroll 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21158 1913 Frizzellburg Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. "natural", or ð 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h h and Mental Hygiene. **7 is marked other than "n** Elementary/Seconday (0-12) College (1-4 or 5+) Modern Comfort Heating/Air Conditioning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joan Carole Berwager-Mildred L. Waddell William J. Colson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Frizzellburg Road, Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health a item 27 i Joan Carole Colson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 injury o 9/29/10 Westminster, MD Meadow Branch Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA any uc-412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HTHEROSCLEROTIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CAMBIOVASCUL Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of) sician and burial-transit executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending pl IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 2 No ed by the a g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? ᅙ 1 Yes 2 No 3 Probably 4 Unknown Completed MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed' death? 1 ☐ Yes 2 ☐ No Yes 2 No certificate : After this certifications and director, I Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA |2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director:

completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier WSZ 201663 6tIVA 30. Name and address of person who completed cause of death (Item/ 23a) (Type, Print)

State Registra

VINCEN

31. Date filed (Month, Day, Year)

TOCCO JE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year May S. Clagett 9:30p M 5 2010 Medical Sept. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Lutheran Village Westminster 8. Date of Birth (Month, Day, Year) May 2 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Director 218-22-7965 Marvland Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Westminster MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21158 205 St. Mark Way, #228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 √ No Specify: white 3 □ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carroll County Elementary/Seconday (0-12) College (1-4 or 5+) Schools <u>Special Education teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Martin Snider Grace Baseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3915 Blossom Valley Dr., York, PA 17402 Rebecca C. Link/daughter permit. Pay.
Department of hs.
Important: If item 27
"ny injury or other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Sep. 20, Hampstead, MD Hampstead Cemetery 2010 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Eline Funeral Home M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21074 Hampstead, Md Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (oras a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed certificate 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical of Vital director, 26. Place of Death (Check only one) Be Other: 2 2 No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dli this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best Medical Examiner: On the basis my knowledge death occured at the time, date and place, and due to the cause(s) and manner as stated. f examination and on investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check of examination Certifying Nurse Praction To the best of vledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tipe of certifier WIL 10 30. Name and address of person who completed cause of death (It 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Cienfuegos Sept. 19 2010 7:30p M Marta Ε. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10520 West Lake Drive #103 Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Righ Funeral /18/1952 Days Hours Min 1 M 2 X F 58 220-29-2564 Director Salvador Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md Montgomery Bethesda 1 ☐ Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10520 West lake Drive #103 20817 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 🔀 No 72 hours after Maryland 21215-0036 1 X Yes 2 □ No Specifi Completed 3 Widowed 4 N Divorced White Year or Dates El Salvadoren the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hair Stylist Beauty Salon 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN Dolores Molina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904. Page 1 and 2 sl tment of Health a tant: If item 27 is jury or other tra Jose Cienfuegos/Son 11416 Stewart Lane Apt A1 Silver Spring, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F.
Important: If ite
any injury or oth 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 9/23/2010 4 Donation 5/ Other (Specify) Chesapeake Crem. Beltsville, Md PHTLTPddD:KTWALDI FUNERAL SERVICE, P.A. KU Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Asthma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sickle cell disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Renal disease or Attending Physician: The law requires that the death certificate be executed burial-vansit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 thek as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) the g Unknown 9 | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 🗀 Unknown 24a Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death? page 2 performed? Yes 2 X N 1 Yes 2 No 25. Was case referred to medical funeral director. æ 26. Place of Death (Check only one) Hospital: Other: 1 XYes 2 🗌 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of hours after death.

neral Director: After the filled in by the funera 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D44239 Sept.21,2010

Registrar

DHMH 17 Rev 7/2009

State

Christian Nwanko M.D. 117 Firstfield Road Gaithersburg, Md 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Walter Counsell Carter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Sept. 26, 1923 Hours Min 301-12-6114 1 X M 2 □ F Months 86 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location Severna Park 10b. County 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Anne Arundel MD 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21146 14 Kimberly Court 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No WW
If Yes, Give Pacif Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. WWII 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Pacific Specify: 3 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Defense Contractor Research Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked of ၉ Sydney Taylor Carter Janet Counsell : If item 27 is marke or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Kimberly Court Severna Park, MD 21146 Mary R. Carter / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Memorial Important: If any injury or once. Elkridge, MD 4 Donation 5 Other (Specify) 2010 . Signatu of Funeral Service Lisenses Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Du as a consequence of): Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) ____ IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year been signed by the atter-should be detached for Month Day ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but or resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsv perform certificate 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 1 Yes 2 No 70 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medical 🔂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5" moun

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day,

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2323 PM Martha Brooks Dickerson September 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner River Kent Hospital Chestertown Center Chester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🛣 F Months Days Hours 218-14-2381 88 09/23/1922 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Director MD Kent Rock Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21661 USA 5804 Waterman's Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐Yes 2XNo Specify Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent <u>Real Estate</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William Webster Brooks Ella Nora White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Dickerson - Husband 5804 Waterman's Way Rock Hall, Maryland 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cemetery 10/01/2010 Rock Hall, Maryland 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 21. Signature of Funeral Service Licensee Keik 130 Speer Road Chestertown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMA 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Fctopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? \$ ar 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 2 No 1 ☐ Yes 25. Was case referred to medica examiner 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760, certificate has been signed by the rector, page 2 should be detached director, this funeral After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evan in the instance of the strain in t

Physician

/Medical

Saltimore, Maryland 21215-0036

6

State

Registrar

Medical

29b. Signature and title of certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 5

eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com

31. Date filed (Month, Day, Year)

29a, Certifier

(Check only one)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 32034

		Registrar		Certif	ficate of	Death			Reg. N	lo.		0200
Physic Medical Exam		n/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death								3. Time of Death 0358 hrs		
		4a. Facility Name (if not institution Chester River Hospita		umber)	4	b. City, Town, or Chestertown	ath	4c. County of Dea Kent				
Funeral Director		5. Social Security Number 216-70-5002	6. Sex	7. Age (In yrs, last 52	birthday) Yrs.	If Under 1 Year Months Days				м/DD/YYYY) 1958	Foreign	nplace (State or ntry) DE •
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Maryland death and Maryland of the filed paid Maryland Hygine 12 is marked other than "natural", or items 23a or 22a-f show any traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County MD Kent 10e. Street and Number 9515 Chantilly	y Farm I a		wn or Location sterto					itizen of Wha		10d. Inside City Limits 1 Yes 2 No
	Completed by Funeral D	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Dive 15. Decedent's Education (Spec	arried 12. Was Dec	cedent Ever in U.S. Forces? 2 No ar ide completed)	1 1 1 Sa. Decedent' during mo	Decedent of Hisp is, specify Cuban, Yes 2 X No is Usual Occupations of working life.	Mexican, Puer specify: on (Give kind o	to Rican, etc.)	No-		etc. Wh iness/In	an Indian, Black, ite dustry
ID 21215-0036 : should be filed within 7 and Mental Hygiene. .7 is marked other than matic event, the Medica	Be	william George	e Newnam					May Pe	earc	е		
and 2 shoul lealth and M tem 27 is m traumatic	유	Steven Donovar		usband)	9515		ly Farn	Lane (Ches	tertow	m, l	MD. 21620
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other trauma		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Kent Cremation 20c. Location - City or Total Cremation 20c. Location - City or Total Crematory or other place) Smyrna, DE							•			
Physician Imbo		2 of atur of F era rvi	H	M00510	· 1 11	Tena Fun 8 West C	tross St	. Galer	na. I	MD 21	635	haech Approximate Interval
/Medical Examiner		ailur List only one cause of Immediale Cause (Final disease or condition resulting in death)	on each line. a. Metha	adone and	oxycdo	one into	xicatio	n Compl	icat	ing		Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a	a consequence of):								
ecuted and transit		events resulting in death) Last	d.	consequence of):	TnorMI	CONO	1/16/70	I/A GIS				
68760, certificate be ex nding physician se as the burial.	n/Medical	X UNPENDED X AMENDED #23a,pt1,11perME,G909,11/16/2010,WS 25a,27,28a-f, per ME G909 11/1/10 TT 23d. Date of deliver								elivery		
Box 68760, e death certificate be the attending physicied for use as the buri	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 1 Yes 2 No 9 V Unknown 9 Unknown								y Year		
P.O.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Atherosclerotic Cardiovascular Disease 1								Probatere autop			
Reco The law ifficate has		25. Was case referred to medical				26 Dlass	4 Darath (Obs.)	perf 1 ✓ Yes	opsy formed? 2 \(\) N	dea	ath? Yes	2 No
Vital hysician this cert	lo Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	npatient 2 ER/0	Outpatient :		of Death (Check other: 4 Nursi	ng Home 5	Reside	ence 6 🗸	Other: S	icene
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be	ation:	27 Manner of Death 280 Date of Injury 29h Time of Injury 29c Injury 1904 D. 1 204 D. 1										
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	4 Homicide determ	nined (Specify)	e of Injury - At home, reside	nce							Route Number, City St
To the Ho within 24 To the Fu completely	Medical	one) 2 Medical Exam	niner: On the basis or and manner sta	t of my knowledge, de of examination and/or ated.								
	Σ	29b. Signature and title of certifier Multiple Signature and title of certifier	melf M	<u> </u>		29c. License r			1	Date signed ober 5, 20		, Day, Year)
		30. Name and address of person w Melissa Brassell, MD		e of death (Item 23a) dical Examiner		nn Street, Bal	ltimore, MD	21201				A
Sta Regist	~~~	31. Date filed (Month, Day, Year)	2010 32. Res	gistrar's Signature	bar	Le!						

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene ? 32035 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 7:00 am Edward T. Deegan September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olneu Montgomery If Under 1 Year g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 🗶 M 2 🗆 F Months Days Hours June 01. Director 119-24-1413 78 New York Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits at 10a, State 10c. City, Town or Location death with the Maryland Director the Medical Examiner must be notified 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20906 U.S.A. 14220 Piccadilly Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1951 ò 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. 1955 Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Lawrence Deegan Mary Burnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. <u> Billie Joyce Deegan - Spouse</u> Silver Spring. 14220 Piccadilly Road. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cem. 109/28/2010 | Silver Spring. MD of Fur eral service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death
8 days Physician Obstructive Luna Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): e attending physician and as the burial-fansit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Renal Failure 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Liver Transplant 24a Was an page 2 s has performed certificate Retroperitoneal Hematoma 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After injury 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Ai completed filled in by the fu 24 hours after death. Funeral Director; A 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) my 5+1 D23630 September 24. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 Frederick Road, #213. Gaithersburg. Maryland 20877 Frank J. Mayo, MD. 31. Date filed (Month, Day, Year) State SFP 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8 PmM 09 2010 21 /Medical 4c. County of Death lame (If not institution, give street and number 4b. City, Town, or Location of Death Examiner on lealth nolu anna 5. Social Security Number If Under 1 Year. If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 81 05/09/1929 RICHMOND, VA Director 578-38-7458 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County 1 ☐Yes 2▼ No Director MD ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code o e with items 23a (iner must b 21401 UNITED STATES 2700 SOUTH HAVEN ROAD by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Yes 2 I If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3 ₩idowed 4 Divorced IIWW 'natural", al Hygiene. d other than "natura event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BRICK LAYER MASONRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I EDITH E. PEAY ဥ JOHN W. DEGEN, SR. traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 2708 VERGELS COURT CROFTON, MD 21114 <u>JOHN W. DEGEN III - SON</u> 20a. Method of Disposition Department of H Important: If Ite any injury or oth once. CHESAPEAKE (CENTER SEPTEMBER 24, CREMATION 1 ☐ Burial 2 Termation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE, ROAD, ANNAPOLIS, MARYLAND of enter the mode of dying, such as cardiac or respiratory 814 BESTGATE 23a Part . Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Amia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 | Yes 2 | №6 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Magnier of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural within 24 hours atter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Pate signed (Month, Day, Year) 29c. License number 29b. Signature and title

3 (v)
State
Registrar

Annap

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

606 Kidgel

Registrar's Signature

CHOPRA

YA

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32037 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 13. 2010 Ewing 2351 Dorinda D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours Year. Months 56 265-25-7491 Director . V<u>irginia</u> June Usual Residence of Decedent 10c. City, Town or Location Bethesda or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 USA 5721 Grosvenor Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?.

1 Yes 2 No Black, White, etc. þ 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Frederick Ewing permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Elizabeth M. Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joan Ewing /Sister in law</u> 121 Waxwing Court, La Plata,MD 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 9/17/10 Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall,MD M00945 21. Signature of Funeral Service Licensee 22 AREHART ECHOUS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Asphyxiation due to choking on food bolus disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 21 0 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2X No
9 Unknown Month Day Year Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure disorder Completed 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Chronic Renal insufficiency , Obesity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 by No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 \square No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 No Accident Suicide Unt Investigation 9/13/10 Eating 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Bethesda Health & Rehab Center 5721 Grosvenor Ln. Bethesda, MD Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61724

State Registrar person who

Py1ès

M.D.

8 2010

30. Name and address of

Tracey Py
31. Date filed (Month, D

8600 Old Georgetown Rd. Bethesda, MD 20814

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signat

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	4	For State Amen		e Type or Pri State of M rMD FCHD KS							-		_	ole.	32038
Physician/	Í	Registrar 1. Decedent's Name		·			<i>Sertifica</i> Frebu		Death		2. Date of De	eath		ear	3. Time of Death
Medical TExaminer	4	la. Facility Name (if	not institution, a	ive street and number)				ty, Town, or	r Location	of Death	Sept		c. County of	210	324 PM
Lamine		Universit	y of n	Namland	Medi	cal Ce	the B	altin	nove				c. County of	Dealii	
Funeral Director	L	214-30-5	710	. Sex 1 ★ M 2 ☐ F	je (In yrs. la 77		may) If Und Month	der 1 Year s Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da April	th ay, Year) 17 ,	1933	. Birthi Coun Mar	place (State or Foreign stry) yland
show dat	-	Jsual Residence of 10a. State	10b. County		10c. City	, Town	or Location							T	10d. Inside City Limits
r 28a-f]	Maryland Oe. Street and Num	Washin	gton				cock			-				1 ☐ Yes 2 No
leath with the Maryland items 23a or 28a-f sho ler must be notified at Fruneral Director		14438 Ho		ad			101. 2		L750				itizen of Wha		
by amir	1	Marital Status Never Marri Widowed		12. Was Decedent Armed Forces? 1 Tyres 2 If Yes, Give Year or Dates.			If Yes, sp	edent of Hi ecify Cuba 2 XNo	n, Mexica	ın, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, \ Specify:	White,	etc.
ithin 72 hours at liene. Triban "natural" the Medical Exa	.[(Spec	15. Decedent's cify only highest	Education grade completed)		(Decedent's Us Give kind of w	ork done d		st of work	ing	16b.	Kind of Busin	ess In	dustry
within giene.		Elementary/Seco	onday (0-12)	College (1-4 or	5+)	11	Welder						Ind	lust	rial
Mental Hygnarked othe atic event,		7. Father's Name (F Freder	First, Middle, Las								e (First, Middle, a Gaski		n Surname)		
2 shou Ith and 27 is m traum	н	19a. Informant's Na Phyllis I									al Route Numbe			e, Zip (lode)
of Hea of Hea If item		0a. Method of Disp	osition	☐ Removal from State		lace of [Disposition (No crematory or	ame of			Date 1		ocation - Cit	y or To	own, State
iit. Pagartment ortant: injury c		4 Donation	5 Other (Spe	cify)			n For	rest			//2010				s, Marylan
permir Depar Impor any ir	4	21. Signature of Fun	Period C	Stan 11	e i						uffer I				21702
Physician/ Medical	١	28a. Part 1. Enter the shock, or heart Immediate Cause (Find disease or condition resulting in death)	Final	mplications that cause on each line cause on each line a. a. Due to (or as			44		g, such as	cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
Examiner	l	Sequentially list con	aditions	Hemor	A		Sho								
xecuted n and al-transit Examiner		if any, leading to im cause. Enter Underl Cause (Disease or ii	mediate lying injury	Due to (or as	a consequ	. (1.	Nass							
e execut cian and nurial-tra		that initiated events resulting in death) L	ast	C. Due to (or as	a conseque			VUSS			-				
physic s the bu	L		•	d											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the burial-transit of the funeral director. After this certificate: To Be Completed by Physician/Medical Exami		FEMALE: 3b. Was decedent properties in the past 12 mround 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death	3		у				23d. Date o Month	f delive	ery Day Year
requires that the de been signed by the should be detached	F	Part II. Other signifi	cant conditions	contributing to death b	ut not resu	ılting in	the underlying	g cause giv	en in Part	1.					ne cause of death?
The law requires cate has been signate page 2 should the Completed											24a. Was		24b. Wer	e autor	osy findings available mpletion of cause of
i: The la icate har, page		5 M/									perfo	ormed?	deat	h?	2 No
hysician nis certifi I director	2	 Was case referred examiner? 1 Yes 2 	_	Hospital:	ent 2 🗆 E	ER/Outp	atient 3 🗆 I	0	er:		k on <i>ly</i> one) ome 5 \square Resid	dence	6 □ Other (S	necify.	}
To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director. Medical Certificate: To Be	2	7. Manner of Death 1 X Natural 2 Accident	5 Pending Investigati	28a. Date of inju (Month, Day	ry 2	28b. Tin inju	ne of	28c. Injury work	at		28d. Describe h			респу	
ital or Atta		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d 28e. Place of Inju- building, etc	c. (Specify)						28f. Location (S City or Tow	ın, State	e)		
the Hospita hin 24 hours the Funeral upleted filler Medical	L	(Check 2 only one) 3	☐ Medical Exam ☐ Certifying Νι	ysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or i	nvestigation, in lge, death occ	n my opinio urred at the	n, death o time, dat	ccurred at	the time, date a	ind place	e, and due to	the cau	use(s) and manner stated
S P Wit	2	9b. Signature and ti	itle of certifier	rup (x	siden	+)	29	IGS Z		e74			ate signed (M		Oay, Year)
OTIVA	Ľ	Matthew	K Folste	completed cause of d	ersity	of 1	oe, Print) Namla:	nd Nu	dical	Cente	r 225.	Green	u St. B	alti	mae Mol 2120
State Registrar	3	1. Date filed (Month,	SEP 2	4 20 0 32. Register	Ir's Signatu		. Spa	Kal			_				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- Registrar Amend Items 23aPtI,25,27,28a-filler of Beath

Registrar Per me 9909, 11/19/2010 and Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:50 pm September 26, 2010 Blanche G. Fersh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 🕱 F 91 Director 104-14-8439 10/14/1918 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intem 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10h County 10d. Inside City Limits ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9318 West Parkhill Drive 20814 u.s.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Education Dental Hygenist/Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Gross Rose Fisher ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Fersh - Son 9318 West Parkhill Drive, Bethesda, Maryland 20814 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Judean Memorial Grdns 09/28/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** failure to trove /Medical Due to (or as a consequence of); Examiner Preumonia Sequentially list conditions, Physician/Medical Examiner dause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last TUTION APPROVED BY MEDICAL EXAMINATION APPROVED BY MEDICAL EXAMINATION OF THE PROPERTY OF THE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Left Hip Fracture IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2₽No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No or Attending Physician: The law 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1**X** Yes 2 √Vo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Vatural Subject fell. 08/24/2010 2 X Accident Unknown M 1 ☐ Yes 2 📥 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living Facility 28f. Location (Street and Number or Rural Route Number, CityApptive 18 4 Hoknown 3616 Littledde Rd., Kensington, MD determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier D69568 2010 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 E Jefferson St, Rockville, MD 20852

DHMH 17 Rev 1/2001

State Registrar

chilakamarsı

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 32040 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Sept. 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8603 Wintergreen Court Odenton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept. 1 **Funeral** 9. Birthplace (State or Foreign 1 XM 2 🗆 F Months Days Hours Min. Country) **Director** Yrs. 055-30-2907 19<u>36</u> New York Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes XX No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8603 Wintergreen Ct., Unit#404 21113 United States 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 □ No
If Yes, Give 1960 6 11, Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Completed Year or Dates.1960-64 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Federal Highway Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Administration Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Fohs Anna Catherine Wersching 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Fohs / Son 10 Hunt Club Ct., Edgewater. MD 21037 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 09/22/2010 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause or each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir physician and the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year as been signed by the a should be detached g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown TENSI 04/Not an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has page performed? certificate 40 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certif 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arvind G 1/41 31. Date filed (Month Di

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jeffrey Fitzgerald	1- For State Certifi	ment of Health and Mental H icate of Death	ygiene 2010 32041
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) JEFFREY FITZGERALD		2. Date of Death Month Day Year September 20, 2010 3. Time of Death 0210 hrs
	Facility Name (if not institution, give street and number) South River Road	4b. City, Town, or Location of Death Edgewater	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Essaina
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	yn or Location	10d. Inside City Limits
and show suce.	MD PRINCE GEORGE'S BOY	WIE	1 Yes 2 No
the Maryland a or 28a-f sh tiffed at once Director	15 20 2 TORRILLE DRIVE	10f. Zip Code 20721	10g. Citizen of What Country? USA
with the 1s 23a of the notif	15303 JODPHUR DRIVE 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 13 Widowed 4 Divorced or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc. Specify: BLACK
"natura Exami	15. Decedent's Education (Specify only highest grade completed) 16a Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind of volume of the during most of working life. DO NOT use retired.) 	
5-0036 ed within 72 hours aft sygiene. Other than "natural" the Medical Examine Completed by	2YRS	MANAGER	PRIVATE
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. In 27 is marked other than numatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) CHARLIE FITZGERALD	18.Mother's Name LOUISE	(First, Middle, Maiden Surname) TURNER
ID 21. 2 should to and Mer 27 is mar To I		9b. Mailing Address (Street and Number or F 15303 JODPHUR DRIVE B	Rural Route Number, City or Town, State, Zip Code) OWIE, MARYLAND 20721
ore, Nest and of Health	20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crem	e of Disposition (Name of cemetery, latory or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If ites injury or other tra	4 Donation 5 Other Specify: HTC	HIAND BIRTAL PARK 9/2 22. Name and Address of Facility J.	962010 RANYULEAVIRGINIA
	(/ B /		D LANDOVER, MARYLAND 20785
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	not enter the mode or dying, such as cardiac c	r respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
	Sequentially list conditions, b.		
seecuted cigan and infal - transit dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Officials or in lary that hillstad		
nted nd ransit	events resulting in death). Last Due to (or as a consequence of): d.		
	UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burdal-transitedical Certification: To Be Completed by Physician/Medical Executed for the control of the completed by Physician/Medical Executed for the control of t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	23d. Date of delivery Month Day Year
P.O. B res that the d signed by the be detached:	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P			24a. Was an autopsy performed? 1 ✓ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
ician: The certifica rector, pa	25. Was case referred to medical examiner?	26.Place of Death (Check	
f Vit Physic er this c rral dire	1 ✓ Yes 2 No	Outpatient 3 DOA Other Nursin	g Home 5 ☐ Residence 6 ✔ Other Scene 28d. Describe how injury occurred
ion of tending Pleath. tor: After the funera	(Month Day Year)		Subject fell off of a pier
Division of To the Hospital or Attending Phewithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral edical Certification: T	3 Suicide 6 Could not be determined (Specify) River	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 48 South River Road, Edgewater, MD
D To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		
To To Go	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) September 20, 2010
0 6	30. Name and address of person who completed cause of death (Item 23a		00,101.100. 20, 2010
(5	Donna M. Vincenti, MD Assistant Medical Examine		D 21201
State Registrar			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2010 Physician/ DOROTHY GOCHENOUR FRANCES 16:20 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAMSPORT NURSING HOME WILLIAMSPORT WASHINGTON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) VA 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 □ M 2 □XF Davs Hours 12/2/1923 226-32-8790 86 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho **Funeral Director** BERKÉLEY FALLING WATERS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 BRYN MAWR COURT 25419 **USA** 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married WHITE 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Divorced 4 Divorced Year or Dates ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry GGive kind of work done during most of working life. DO NOT use retired)
HOMEMAK ER (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RUTH COFFMAN WILLIAM GOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION A. GOCHENOUR (SPOUSE) 26 BRYN MAWR COURT, FALLING WATERS, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott ROSEDALE CEMETERY 1 X Burial 2 Cremation 3 Removal from State MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death PNEUMONIA ASPIRATION Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner WCZHAGIA attending physician and for use as the burial-transit signed to has been sig je 2 should b

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate had funeral director, page

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

-	Sequentially list conditions,	b				
Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence of): Due to (or as a consequence of):	EBRAL INFI	ARCTS	>	
edical		■ d				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 V No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
à	Part II. Other significant conditions of	contributing to death but not resulting in the under	ying cause given in Part I.		obacco use contribute to Yes 2 ⊠No 3 □ F	the cause of death?
Completed				24a. Was autoj perfo 1 D Yes	psy prior to prmed? death?	topsy findings available completion of cause of
Be	25. Was case referred to medical		26. Place of Death (Check	k only one)		
일	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing Ho	ome 5 Resid	dence 6 Other (Spec	sify)
Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation		work?	28d. Describe h	now injury occurred	
	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		actory, office	28f. Location (8 City or Tow	Street and Number or Ru vn, State)	ral Route Number,
Medical	(Check 2 Medical Exam	ysician: To the best of my knowledge, death occur niner: On the basis of examination and/or investigation rse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at	the time, date a	and place, and due to the	cause(s) and manner stated
_	29b. Signature and title of certifier	_	29c. License number		29d. Date signed (Mont	h, Day, Year)

D33700

OCTOBER 3, 2010

WILLIAMSPORT

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

TIZAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death

Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 7:40 AM 9 24 2010 Mildred Griffin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown Funder 1 Year | If Under 24 Hrs. Kent Chestertown Nursing & Rehab. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 □ M 2√2 F 215-20-0105 Director 02 5 1913 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. My dical Examination to confire 4 at once. Kent Worton 1 ☐ Yes 2 🛣 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 24851 Lambs Meadow Rd 21678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ∐Yes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lite. DO NOT use retired) Factory Worker Elementary/Secondary (0-12) College (1-4or 5+) Vita Foods. th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Flamer Lolita Miller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 Calvert St. Chestertown, MD 21620 Rosinda Menter-Daughter 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) : 10/2/2010 Worton, MD Olive A.M.E. 21. Signature of Funeral Service Licensee 22. Name and Address of Facilities Renneth Walley Funeral 00026) Service 821 W. St. Annapolis, MD 21401 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** Umonany nuntes disease or condition resulting in death) /Medical Due to (or as a consequence of): 0 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PAD @ TYPE II DM @ SIP AKA Ole 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 Z-NO 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/1/ Mlun, MD D21313 9/28/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 Washington Are, Chastestown, MD 21620 KINK, WUN, 31. Date filed (Month, Day. Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene
Amend Items 28a-i per me, g908, 10/20/2010dib

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRANKYE V. GILLIKIN 0915 M SEPT. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROGIONAL LALISBYER HICAMICA TENINSULA Social Security Number If Under 1 Year If Under 24 Hrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** yrs. 85 1 D M 2 X Months Days (Month, Day, Year) 9-21-1925 Hours Min. Director 224-30-333 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. SOMERSET PRINCESS ANNE 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country?
UNITED STATES Funeral 10434 EAGLE DRIVE 21853 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER HOMEMAKER Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important; If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LONNIE MOUNCE THELMA FASH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIKE GILLIKIN SON 10440 EAGLE DRIVE, PRINCESS ANNE, MD. 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9-29-2010 SALISBURY CREMATORY Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINMAN FUNERAL HOME, Princess Anne, M M00295 11673 Somerset Ave., 21853 Md. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Im rediate Cause (Final Interval Between Onset and Death Physician/ d ease or condition resulting in death) Medical Due to (or as a nsequence of) **Examiner** mone Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 2 No Yes **Division of Vital** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending Subject slipped and fell. 08/20/2010 10:00 am 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 10946 Eagle Drive, Princess Anne, MD determined Home Princess Anne, Hospital 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of, 29c. License number **048552** 29d. Date signed (Month, Day, Year) SEPT. 24, 2010 HOLZWORTH

Registrar DHMH 17 Rev 7/2009

State

SADIQ 31. Date filed (Month. Da SALISBURY Md. 21801

SNOW ST.

263

son who completed cause of death (Item 23a) (Type, Print)

r's Signature

Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** \mathbf{p}^{M} John Gaskins 3:24 2010 09 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cheverly Prince Georges Gladys Noon Spellman Nursing Home
5. Social Security Number 6. Sex 7. Age (In yrs. rast birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F 79 226-36-8004 Director 08 - 20 - 31VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir then "natural", or itams 23a or 28a-f show the Medical Exeminer must be notified at 10d. Inside City Limits 1 Yes 2 ☐ No Director MID Charles waldorf 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 8020 Holly Avenue 20601 death v USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Wes 2 No 1952 If Yes, Give Year or Dates: 1954 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed be filed within 72 hall Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Government permit. Pages 1 and 2 should be fit Department of Health and Mental Hy important: if item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gaskins Mary Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Britton/Daughter 8020 Holly Averue Waldorf, MD. 20601

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Church Cem. 10/2/10 Kinsale, VA. 22. Name and Address of Facility Weldon-Fisher Funeral Home 21. Signature of Funeral Service License Whileker ediel <u>22883 Kings Highway Warsaw, VA.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Septicemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Gram Positive Cocci Due to (or as a consequence of): Examine be executed the burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical The law requires that the death certificate use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached Records, P.O. the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Acute Renal Failure 1 Yes 2X No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cerebral Infarction autopsy performed? certificate 2√ No Encephalopathy 1 Yes 1 Yes Division of Vital 2 ₹ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: XNatural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No d in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number uli) D0026024 September 24,2010 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) Lester Milsi, MD 1160 Varnum Street N.E. Washington D.C. 20019 37 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 29 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept 25, 2010 Delores Louise Gryszkiewicz 10:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 10505 Cedarville Road 13-1 Brandwine If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 M 2 XX June 16, 1931 Mary Tand Director 577 44 7368 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Prince George's Brandywine 1 🗆 Yes 2 📉 Maryland 10e. Street and Number ō 10f. Zip Code 10q. Citizen of What Country? Funeral 23a 10505 Cedarville Road 13-1 20613 United States hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 X Widowed 4 Divorced Specify White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)
Secretary (Specify only highest grade completed) than Elementary/Seconday (0-12) Coilege (1-4 or 5+) and Mental Hygiene. State Attorney Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Warren Ryder Cora Wood permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15820 Westwood Road, Brandywine, MD 20613 Mickey Gryszkiewicz (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Oct 6, 2010 Cheltenham, Maryland 21. Signatur of Foreral Service accesses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Athorosolesake and Hypertensive to (or as a consequence of): heart disease. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed -trans and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ my or under Interchoo Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification D0028035 m()

State Registrar KOLIAMO.

F.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASIRMOHMAD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** September 01.53 AM aril leresa 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 M 2 X F 07/03/1962 48 DC Director 577-90-4071 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2X No Director Prince Frederick MD Calvert 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Francisco. 4890 Dennis Monnett Road 20678 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates 1 Never Married 2 X Married 2 X No 1 Yes 2 X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Relocation Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myles Torreyson Elizabeth Tolson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Grill / Husband 4890 Dennis Monnett Rd, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🔲 Removal from State Resurrection Cemetery 09/28/2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. of Funeral Service Licensee CINY 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final esophagea Physician metastatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached for Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š þe 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Hospital: 1 Unpatient Other: 4 Nursing Home 1 Tes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 28b. Time of 28c. Certification: 1 Natural 5 Pending investigation Injury s after death. 1 TYes 2 Accident 6 Could not be determined 3
Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide To the Hospital within 24 hours a To the Funeral C completely filled the Hospital 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified RES - 000 September 22 2010

State Registrar

DHMH 17 Rev 1/200

address of person who completed cac

31. Date filed (Month, Day, Year)

SEP 27 2010

(Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

se of death

10-07191 Christine Gowen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 32048

		1- For State Registrar	,	Cer	tificate of	Death		,	teg. No.		204
Physici	an/	1. Decedent's Name (First, Midd						2. Date of Dea Month	Day Yea	3. Time of	
Modical Exami	ner	CHRISTINE	LOUISI		GOWEN	0" -		Septembe	er 18, 2010	0/50	nrs ————
N		4a. Facility Name (if not institution 1678 Albermarle Driver)		nber)	41	Crofton	Location of	Death	4c. County of		
Funeral		5. Social Security Number		7. Age (In yrs. la	st birthday)	If Under 1 Yea	r If Under	24Hrs. 8. Date of Bi		9. Birthplace (Sta	ite or
Funeral Director						Months Day		Min		Foreign	
		227-37-8354 Usual Residence of Decedent	1 M 2 X	2	4 Yrs.			0001.3	1985	VIRGIN	IA
any		10a. State 10b. County		10c. City,	Town or Locatio	n				10d. Inside	e City Limits
	_	MD ANNE	ARUNDEL	C	ROFTON					1 Yes	2 XXIIo
Aaryland 28a-f show 1.at once.	cto	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zip Code		1	l0g. Citizen of Wh	nat Country?	
th the Maryland 23a or 28a-f sho notified at once.	Director	1678 ALBERM	ARLE DRIV	JΕ		2111	4		U. S	. A.	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	eral	11. Marital Status		dent Ever in U.				? (Specify Yes or No		- American Indian,	Black,
death r iten	盲	1 XXVever Married 2 N	larried Armed For	ces?	If Yes	s, specify Cubar	ı, Mexican, P	uerto Rican, etc.)	White	e, etc.	
after al", o	by F	3 Widowed 4 Di	vorced If Yes, Give Year or Dates:		1 🗆 🔌	Yes 2XXNo	specify:		Specify:	WHITE	
nours		15. Decedent's Education (Spe			16a. Decedent's	s Usual Occupat st of working life			16b. Kind of Bu	siness/Industry	
1215-0036 Id be filed within 72 hou fental Hygiene. narked other than "natevent, the Medical Exs	Completed	Elementary/Secondary (0-12)	College (1~	4 or 5+)		GE STU			IINITAE	RSITY O	c MD
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	om	17. Father's Name (First, Middle		<u> </u>	COLLE			Name (First, Middle,			. 1410
15-	ക	JOSEPH FRAN		V				HELE ANN			1
T 2 2 2 3	o B	19a. Informant's Name/Relations			19b. Mailing	Address (Stree		er or Rural Route Nur			
ore, MD 21 es 1 and 2 should I of Health and Mer If item 27 is man		JOSEPH F. G	OWN/FATHI	ΞR	6142	нимрва	CK W	HALE CT.	WALDORF	MD 206	03
e, N l and Health item		20a. Method of Disposition		20b. P	lace of Dispositi	on (Name of cer		Date	20c. Location -	City or Town, State	,
Baltimore, permit. Pages I as Department of He Important: If ite		1 Burial 2 X Crematio		II State	•	,	TOPY	22,2010	CLEN	BURNIE,	MD
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other S 21. Signature of Funeral Service		n i	22. Na	me and Address	of Facility	AYMOND F	TINI. 6	PDITTOP	11D
Dep Dep Dinjin		fond BI	1 Jan	МОО	641 56	35 WAS	HINGI	ON AVE.,	LA PLA	TA.MD 2	0646
Physician		23a. Part I. Enter the disease, of failure. List only one cause								art Approxim	nate Interval Onset and
/Medical Examiner		Immediate Cause (Final disease		Alcoho!	l Intoxi	cation					eath
£xaiiiiiei		or condition resulting in death)	Due to (or as a c								
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	concoduonce of	٨٠						
	i	cause. Enter Underlying Cause (Disease or injury that initiated		onsoquence or,	,						
sit d	Examiner	events resulting in death) Last	Due to (or as a c	consequence of):						
760, icate be executed physician and the burial - transit		- INDENDED	d	232 27	282-f r	or me c	908 1	0–15–10 vt	-		
O, e be e /sicial burial	Medica	X UNPENDED				JCI MC E	,,,,,,	0 15 10 11		al a this area.	
8760, ifficate bo		IF FEMALE: 23b. Was decedent pregnant in t		utcome of pregn th	_	I death 3	Ectopic p	regnancy	23d. Date of Month	Day	Year
Box 68 e death certifi the attending	icia	past 12 months?	lunarum I '	nt at time of dea	th =	er (Specify)			4		
Bo ne dea the a	Physician/	1 Yes 2 No 9 V Un	3 Olikilov				i i i B	Loop Dida	-h	bute to the cause of	Calcook 2
i, P.O. Bc ires that the des signed by the a	by F	Part II. Other significant condi	tions contributing to	death but not re	suiting in the un	deriying cause g	jiven in Part			Probably 4	,
S, T	<u>8</u>									Vere autopsy finding	
ords, aw requir nas been s 2 should	ompleted							autop	osy p	nor to completion of eath?	
Rec The I	Son							1 Yes			No
Vital Rec ysician: The list certificate list	Be	25. Was case referred to medical examiner?	Hospital:				Other	heck only one)		el ou	
Physi ral di	ို	1 Yes 2 No 27. Manner of Death	28a, Date o		ER/Outpatient 28b. Time of Inju		ry at Work?		Residence 6 w		
n of rding Pl h.: After e funeral	<u></u>	1 Natural 5 Pen	(Month, I	Day, Year)	fd 7:30a		res 2 X N	_		-	
Sio	cat	2 Accident Inve	stigation 28e Place		me, farm, street,	аш		UIIKIIOW		er or Rural Route No	umber, City
Division of Vital Records, rate or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should	Certification	dete	Id not be (Specify)	hou		,, <u>-</u>	g,	or Town, S	State)	Dr. Crof	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier	hysician: To the best			ed at the time, da	ate and place				
thin 2 the I	Medical		miner:On the basis of and manner sta	examination an							
F 8 5 8	ş	29b. Signature and title of certifi		iteg.		29c. Licens	e number		29d. Date signe	ed (Month, Day, Yea	ar)
		Lano h Prush	all mit			O.C.I	M.E.		September	18, 2010	
		30. Name and address of person	who completed cause	of death (Item:	23a)	<u> </u>		F 2016.			
		Pamela E. Southall, N		ledical Exar		Penn Street	t, Baltimo	re, MD 21201			
	ate	31. Date filed (Month, Day, Year)	32. R/9	istrar's Signatur	e h 1						
Regis		UU1.	S CUIUI SA	wind of	y Agree	K. I					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		and M		40. 40. 1	0	2201.0
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death			Reg. No.	0	32049
	Physicia Medic		Evelyn R. Garbe			2. Date of Dea		⁄ear	3. Time of Death 7:20am M
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	of Death		4c. County of	Death	, , , ,
			486 Holiday St.	Odenton			Anne	Arur	nde1
I	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours	24 Hrs. Min.	8. Date of Birth	h		ace (State or Foreign
	Director		524-22-0831 1 M 2XXF 95 Yrs.			Month Day 11/12/	1914	Count	" IL
	ind show at	'n	10a. State 10b. County 10c. City, Town or Lo	ocation				10	d. Inside City Limits
	faryla Ba-f s tified	Director	MD Anne Arundel	Odenton					1 ☐ Yes 2X No
	or 2		10e, Street and Number	10f. Zip Code			10g. Citizen of Wh	at Count	ry?
	s 23a	Funeral	486 Holiday St.	21113			USA		
	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Spec	ify Yes or No-	14. Race -		
36	after (", or camir	l by	1 X Never Married 2 Married 1 Yes 2XX No	1 ☐ Yes XX No <i>Specify:</i>		ican, etc./		White, et	ic. Nite
8	ours artura	Completed	Year or Dates.				Specify:		
T.	72 h in "na Medik	npl	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most O NOT use retired)	t of working	g	16b. Kind of Busi	ness Indi	ustry
272	within giene. er tha		College (1-4 or 5+)	nalyst			D.0	.D.	
b	be filed vental Hygerked other	Be	17. Father's Name (First, Middle, Last)		er's Name	(First, Middle, N	Maiden Surname)		
<u>yla</u>	ld be Ment arked artic e	욘	Edward R. Garbe	Bert	ha R	ossruck	er		
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Maili	ng Address (Street and Number	er or Rural	Route Number,	City or Town, Stat	e, Zip Co	ode)
e o	and 2 dealth am 27 ther to			Duke of Glouce	ester	St. A	nnapolis	, MD	21401
20	a 0 4- 1-			natoni or other place)	Da 7 / 2 7 /		20c. Location - Ci	ity or Tow	n, State
Baltimore,	it. Page intment o intant: If injury or			Cemetery	9/27/		Odenton,		P 70 7
Ba	permit. Page Department Important: I any injury o		21. Signature of Superal Service Licensee	2. Name and Address of Facility 51 Annapolis R	Har	desty F Gambril	uneral H .1s, MD 2	ome,	P.A.
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent						Approximate
A I	nysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			. ,			Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Carcinomatosis Due to (or as a consequence of):					+	
	Examiner	_	Sequentially list conditions, b. Metastatic Breast	Cancer					
-	n #	iner	if any leading to immediate Due to or as a consulence of cause. Enter Underlying						
	executed an and rial-transi	Examine	Cause (Disease or linjury that initiated events c.						
_	a = -	dical	resulting in death) Last Due to (or as a consequence of):						
3	death certificate be he attending physicis ed for use as the bur	edic	d						
20x 68/	certifi nding ise as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				20d Date 4	حددالما الما	
Š	eath a atte	icia	in the past 12 months? 1 ☐ Ves 2 ▼ No. 1 ☐ Ves 2 ▼ No. 1 ☐ Ves 2 ▼ No.	Ectopic pregnancy Other (specify)			23d. Date of Month		y Day Year
o.	the d by the	hys	9 ☐ Unknown						
Z.	s that gned se det	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		23e. Did tob	acco use contribu	te to the	cause of death?
g Š	equire een sij ould b	ted	Atrial Fibrillation			1 □ Y∈	es XX No 3	Proba	bly 4 🗆 Unknown
Vital Records,	law re	Completed	Hypertension			24a. Was ar autops	v prio	r to com	y findings available pletion of cause of
Ž	: The cate h	Ç				perform	ned? dea	th? Yes 2	
<u> </u>	ician certifi ector	Be	25. Was case referred to medical examiner?	26. Place of Death	h (Check o	nly one)_			
>	Phys	일	1 ☐ Yes 2 ★No 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of injury 28b. Time of	t 3 DOA Other: 4 Nur 28c. Injury at			nce 6 Other (S	Specify)	
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death certifics within 24 herous after death. To the Furherous after death. To the Furherous Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to a subject of the funeral director.	Certificate:	15€ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 1	- 1	d. Describe ho	w injury occurred		
3	After or dea ector by the	ŧ	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		-	f, Location (Str	reet and Number o	r Rural R	oute Number.
_ ≥	tal or s afte al Din		building, etc. (Specify)			City or Town,			9.
	lospid t hour uners	Medical	29a. Certifier (Check (2 Medical Examiner: On the basis of examination and/or invest	ccured at the time, date and pl	lace, and	due to the caus	e(s) and manner a	s stated.	
	the hin 24		only one) 3 Certifying Nursa Practioner: To the best of my knowledge, of	leath occurred at the time, date a	and place,	e time, date and and due to the d	d place, and due to cause(s) and manne	the cause or as state	e(s) and manner stated. ed.
	© 1 ₹ 0 0		29b. Signature and title certhier	29c. License number		29	9d. Date signed (M		y, Year)
	PA			D0063145			9/21/	ZU10	
5	dr.2	- 1	30. Name and address of person who completed cause of death (Item 23a) (Type, F Arvind Desai 705 Digital Dr. Linthi	rint) cum, MD 21090					
	State		31. Date filed (Month, Day, Year) 32. Begietrar's Signature						
	Registra	r	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's A.	arke					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9/17/2010 6:00pm M Alverta Prout Gibson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Solomons Solomons Nursing Center If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral 1 □ M 2**XX** (Month, Day, Year) 4/15/1930 Director 213-28-4087 80 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2XXNo MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 20768 USA 420 West Dares Beach Rd. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes ZXNo ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. White If Yes, Give Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. arked other than ' Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) 12 F.D.I.C. Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edward William Prout Emily Moreland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6120 Alpine Ct. Sunderland, MD 20689 Diana Penn Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State 9/21/2010 4 Donation 5 Other (Specify) Mt. Zion Cemetery Lothian, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Vals 905 Galesville Rd. Galesville, MD 20765 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Intracerebra Physician disease or condition resulting in death) Medical Cardio Vascular directo Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death n signed by the ar g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown COYONANY cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Dementio 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p. Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D. 50653 9-20-2010 eur ano C. SDIEANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aYAN

Registrar

State

857

31. Date filed (Month, Day,

Deale

62. Registrar's Signature

12000

			For State Registrar	Please			d / Depa		Health and N	lental Hyg	Are Legible. giene leg. No2 () ()	32051
	Physicia /Medic		1. Decedent's Name (Fi	3 M	· GAI	RDNEI	e			2. Date of Dear	th Year	3. Time of Death 1945 M
Pt.	Examin	er	4a. Facility Name (If not Anne Arund	el Med	ical Ce	nter		Anna	r Location of Death		4c. County of Dea	undel
	Funeral Director		5. Social Security Numb 212-44-542		Sex 1 M 2□F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign ountry)
Aaryland	f show	or		b. County Anne A	rundel	10c. City,	Town or Lo	cation lgewater				10d. Inside City Limits 1 ☐ Yes 2€No
with the	3a or 28a- it be notif	Funeral Director	10e. Street and Number		t RD.			10f. Zip Code	21037	1	10g. Citizen of What C	ountry?
5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual trust be notified at once.	þ	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dec Armed Fo 1Yes If Yes, Gi Year or D	≱(∑ No ve		Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Z I 3-0 thin 72 hor	ne. Ian "natur Modical E	Completed	15. (Specify of Elementary/Secondar		ducation rade completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of work		16b. Kind of Business	·
d be filed w	and Mental Hygier s marked other th numatic event, th	To Be Cor	17. Father's Name (Firs			<u> </u>		Coach	18. Mother's Name	e (First, Middle, i		1 Football
, Mary and 2 shou	aalth and M 27 is mar er traumat		19a. Informant's Name Marcia Gar		(Type. Print) Wife		l		and Number or Rur Point Rd.		r, City or Town, State,	
altimore	ment of He ant: If Iten ury or oth		20a. Method of Disposit 1 🌇 Burial 2 🗆 C 4 🗆 Donation 5 🗆	remation 3		State		sition (Name of matory or other pla Cemetery	i	Date 22/2010	20c. Location - City o	
Dall permit.	Depart Import any inj once.		21. Signature of Sunet	a Service Lice	ensee			2. Name and Address 2 Ridgely			uneral Hom s, MD 2140	
. 1	nysician Medical		23a. Part1. Enter the d shock, or heart fa Immediate Cause (Fina disease or condition resulting in death)	ilure. List only	y one cause on a	caused the death. each line. ROKE (or as a conseque		er the mode of dyi	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
executed	sician and burial-transit	al Examiner	Sequentially list condition any Leading to mine-cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	ons, hate ig ry	c	PERT (ur as a conseque (or as a conseque	ence off:	OW.				years
DIVISION OF VITAL RECORDS, F.O. BOX 68/00, to the Hospital or Attending Physician; The law requires that the death certificate be	been signed by the attending physician and should be detached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	1 Live	tcome of pregnar birth 2 Petal mant at time of de nown	death 3[⊒ Ectopic pregnan ⊒ Other <i>(specify)</i> _	су		23d. Date of d Month	elivery Day Year
law requires that	n signed build be deta	by P	Part II. Other significan	nt conditions BETS		eath but not resul	Iting in the u	nderlying cause gi	ven in Part I.			to the cause of death? Probably 4 Unknown
al neco	icate has been, page 2 sho	Completed				_				24a. Was a autop perfor 1 Yes	sy prior to	
OI VILAI Physician; T	this certif al director	To Be	25. Was case referred examiner? 1 Yes 2 No 27. Manger of Death	to medical	Hospital: 142		ER/Outpatier	IL 3 LI DOA		ome 5 ☐ Resid	lence 6 □ Other (Sp	necify)
DIVISION al or Attending	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification: To	1 XNatural 5 2 ☐ Accident	Pending investigation Could not lead termined	(Mon on De 28e. Place	ith, Day, Year)	Injury me, farm, str	Wo	ryan rk?]Yes 2 □No		ow injury occurred Street and Number or I In, State)	Rural Route Number,
he Hospita	in 24 hours he Funera pletely fille	Medical (ıminer: On the b						cause(s) and manner date and place, and d	
Tot	To the com	Σ	29b. Signature and title	of certifier	Krie	glR, M	D	29c. Licen	4838	:	29d. Date signed (<i>Moi</i>	nth, Day, Year)
H	12		Name and address SUS AW H 31. Date filed (Month, E	KRIEC	SER NUN	of death (Item			Auna	polis,	mi 214	01
	Sta Registra	-		EP22		leneva	A. 19	parts	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year THUEEN 00 325 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12217 Tulip Grove Dr. Prince George's Bowie Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. July 6 1921 89 Yrs Pennsylvania Director |194–12–7136 Usual Residence of Decedent show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12217 Tulip Grove Dr. 20715 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 🔯 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3x Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetin. Elementary/Seconday (0-12) College (1-4 or 5+) Dental Hygienists Dental Offices Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mark Gallagher Nellie Kina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Gallagher/Daughter 12217 Tulip Grove Dr., Bowie, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Burial 2 Oremand. 4 Donation 5 Other (Specify) Arlington Nat'l Cem. 10/20/2010 Arlington, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) men EN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-1 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year the 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? performe Yes 2 N certificate 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 **X**No Other: 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 100 Natural 5 Pending work? Accident М 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined م. م 24 hou. **د the Funeral D** completed fille Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 7:47AM Roberta Garrett 2010 SEPTEMBER 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 🔀 F 81 185-50-8662 July 17, 1929 Director Alabama Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Prince Georges Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2559 Markham Lane 20785 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John C. Springer Alberta Hutchinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Geraldine Scott - daughter 2559 Markham Lane, Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Greendale Cemetery 10-2-2010 Masontown, PA 22. Name and Address of Facility J. K. Johnson Funeral Home, P. A. 21. Signature of Funeral/Service License 6503 Old Branch ave., Temple Hills, MD 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Disease of the Breast /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the bunial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the bunia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 2**X**No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 this certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No ER/Outpatient 3 □ DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural 2 Accident Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check only one)

30. Name and add

29b. Signature and tifle of certifie

PIN DELL SEP 2 8 2010

SING

ss of person who completed cause of death (Item 23a) (Type, Print)

14300

32. Regitrar's Sanstill

M.D.

29c. License number

GALL ANT FOX LANZ

29d. Date signed (Month, Day, Year)

50172 124

BOWIE

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 23. 2010 Ruth K. GROEMPING 9:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens Nursing Home Silver Spring Prince Georges . Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🕠 F Ma(1975, Day 1914 578-48-4780 96 Germany Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Maryland Prince Georges Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Ves 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department Manager German Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Kuczka Hedwig Dorothea Heinrich t. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is markingry or other traumatic 19a. Informant's Name/Relationship (Type, Print)
David Groemping, Grandson 19b. Mailing Address (Street and Number or Rural Route Number, City pr Town, State, Zip Code) 1411 Highland Drive, Silver Spring, MD 20910 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) <u>Metropolitan Crematory 09/24/10</u> Alexandria, VA of Fun cal Service Livenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Approximate Interval Between Onset and Death 1 Month Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) b the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has performed? Yes 2 X No After this certificate ! 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No မ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending in 24 hours after deaunthe Funeral Director: Aft work' ☐ Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R15866 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Eileen Gemmell,

31. Date filed (Month, Day, Year)

CRNP,

27 2010

3160 Gracefield Road, Silver Spring, MD

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 2010 1320 George Joseph Hogan, Jr. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick Mount Airy Kline Hospice House 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Hours 214-28-0040 1 🕱 M 2 🗆 F June 20, 1930 80 Mary Land Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov 10a. State death with the Maryland Examiner must be notified at Director Frederick 1 Yes 2 X No Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number items 23a Funeral 21704 9007 Reichs Ford Road United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc o þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic Elementary/Seconday (0-12) College (1-4 or 5+) Masonry Mason Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Naomi Hildebrand 2 George Joseph Hogan, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9007 Reichs Ford Road, Frederick, Maryland 21704 19a. Informant's Name/Relationship (Type, Print) Irene E. Hogan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 10, 1 Burial 2 K Cremation 3 Removal from State Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 2010 Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ DINOMO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death Unknown page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 KNO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? 2 100 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ieral Director; After this filled in by the funeral dit 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 A injurv 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature : 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mont)

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 21, **Physician** LEVIN HOOVER September 2010 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Maryland 215-12-3027 Director Aug. 9, 1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2X No Maryland Director Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5209 Frances Road 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ NoWorld If Yes, Give Year or DateWar II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2□NoWorld 1 ☐ Yes 2 💆 No White Specify Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Copper Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Peter Hoover Sally Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Clark (Cousin) 5711 Luther Miles Lane - Marion Station, MD 21838 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 9/22/2010 Delmar, Delaware 21. Signary Fune I Hylice licens.

Mary Bethy Bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of): signed by the attending physician dbe detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed need Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No performed? 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ဥ 1 | Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hall Highway Criefield MN 2119

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

aumburation

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department /	ent of H 010dhb ate of L	lealth a <i>eath</i>	nd Me	ental Hy	giene Reg. No.	2010	32057
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Lawrence Hunt			2	2. Date of Dea Month		Year	3. Time of Death
	Medic Examin	al		ity, Town, or	Location of		epembe	\neg	County of Deal	
)			ndsor				В	altimo	
ı	Funeral Director		219-26-7931 ¹¼м₂□F 71	hs Days	If Under 2- Hours	Min.	Date of Birt (Month, Day - 1 2 - 1	, Year)	9. Bir Co MD	thplace (State or Foreign untry)
	land show dat	ᅙ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits
	e Mary r 28a-f notifie	Sirec	MD Baltimore Windsor Mi							1 ☐ Yes 2X No
	with th	Funeral Director		Zip Code 1244				10g. Citiz	zen of What Co	ountry?
	death items ner mu		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	cedent of His	spanic Origin	n? (Specif	y Yes or No-		4. Race - Ame	
036	s after ral", or Exami	d by	1 U Never Married 2 U Married 1 Yes 2 No	s 2 X No			,	s	Black, White Specif Bla c	
2-0	2 hour "natul edical	Completed	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of u			of working		16b. Kin	nd of Business	Industry
7121	vithin 7 liene. sr than the Ma		Elementary/Seconday (0-12) College (1-4 or 5+) Ife. DO NOT (1-4 or 5+) S+ Ministe	use retired)	J	3		Min	istry	
nd	e filed v tal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last)				irst, Middle,		urname)	
ıryla	ould be nd Men marke imatic	-	Edward Hunt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addri	ann /Strant a			McKir		Town State 7in	Code
Σ,	nd 2 sh ealth ar n 27 is ier trau		Tool Maining Addition							21244
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Note The Proposition of Note The Prop	or other place	!	Dat			eation - City or	
Balti	permit. F Departm Importa any inju once.		21. Signature of Fundal Service Licensee 22. Name Benn	and Address	s of Facility	917	' W.]	sab	ella S	St.
			Fune 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure dist only one cause on each line.						MD 218	Approximate Interval Between
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)							Onset and Death
	Examiner		- Due to (or as a consequence of):							
	ji q	Examiner	Sequentially list conditions, b. — Due to (or as a consequence of): cause. Enter Underlying							
	icate be executed in physician and is the burial-transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last							
09	te be e hysicia he buri	edical	d							
687	ertifica ding pl se as tl		IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy							
Division of Vital Records, P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1					23	3d. Date of del Month	Day Year
s, P.O	ires that the signed by do be detailed	by	Part II. Other significant conditions contributing to death but not resulting in the underlyin	ng cause give	en in Part I.				/	the cause of death?
ord	w requisite sections is been 2 should	Completed					24a. Was a	ın	24b. Were aut	topsy findings available completion of cause of
Rec							autop: perfor 1 Yes	med?	death?	2 No
/ital	/sician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Other	ce of Death			c [Other (Speci	:E.)
10	Attending Physician: ar death. ector: After this certific by the funeral director,		27. Manny of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury	28c. Injury work?	at	-	. Describe ho			11/1)
Sion	I or Attendii after death. Director: At I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined		′es 2□N		Location (St	reet and	Number or Rui	al Route Number,
Σ	pital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director,		building, etc. (Specify)				City or Town	n, State)		
up.	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured 2 Medical Examiner: On the basis of examination and/or investigation, in Certifying Nurse Practioner: To the best of my knowledge, death occured to the best of my knowledge, death occurred to the best of my knowledge.	in my opinion	ı, death occı	irred at the	time, date ar	id place, a	and due to the c	ause(s) and manner stated.
	viit Pou		29b. Signature and title of certifier MSkayspannel MID	9c. License	number 0057	465			signed (Month	
	Pal			Av - 5	- 203	, Ba	Inm			
	Stat Registra	e ır	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. S. RAJAPAKE, M.D. 2835 Smith 31. Date filed (Month, Day, Year) SEP 27 2010 32. Registrar's Signature SEP 27 2010							
				_			_		_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Amend#18. PerFHFCC10-6-10cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** $1:21 p_{M}$ 2010 Franklin Delano Hartley September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Frederick Calvert Memorial Hospital Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth (Month, Day, May 25, 5. Social Security Number **Funeral** 1 XM 2 ☐ F Months Days Hours Min. 238-52-7254 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits f show 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director Arlington VA Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22204 USA 1926 S. Pollard St. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No 11/55 If Yes, Give Year or Dates: 8/57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 0. Maryland 21215-0036 1 ☐Yes 21 No Specify: SpecifWhite 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: If them 27 is marked other than "ne any injury or other traumatic event. In any once. Elementary/Secondary (0-12) College (1-4or 5+) US Government Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Young Goodwin Leona Irene Young Rhonda Kilby Hartley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1926 S. Pollard St. Arlington, VA 22204 Rebecca I. Mathews/Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct. 2,2010 Fairchance, PA Maple Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Linensee 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA 22203 Turkano 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUDDEN CAZDIAC Physician disease or condition resulting in death) /Medical Examiner ORUNAZY fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ HEARI 1 ☐ Yes 2 No 0~65577VE 3 Probably 4 Unknown Completed DIASETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signa 25203 9-25-2010 EMERGENCY MEDICINE 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) CHRISTOFHER MORROW MY MEMORIAL H 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra AMEND#19bperFH, 10/6/10, BMN, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Emanuel HARAD September 26, 2010 Physician/ 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 14, earl 919 Pennsylvania M 2 🗆 I Director 222-07-5177 90 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 810 Hyde Court Funeral United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Drafting Engineer Getty Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Levitt Joseph Harad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Hyde Court, Silver Spring, MD 20901-19a. Informant's Name/Relationship (Type, Print) Judith Riebman, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Jewish Community Cemetery 09/28/10 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Wilmington, DE Torchinsky Hesirew Funeral Home 254 Carroll St., 20012 _NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA (Mysician) disease or condition Medical resulting in death) Examiner ORGANISMS Division of Vital Records, P.O. Box 68760FIED Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last the buria Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law page perform 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. 1 Yes 2 No Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifier 10 30. Name and address of person who completed puse of death (Item 23a) (Type, Print) 760 2 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. \angle 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician <u>entember</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 X M 2 □ F 1957 Maryland August 13. **Director** <u> 215-72-9640</u> Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show her must be notified at 1 Yes 2 No Gaithersburg Maryland Directo Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20878 United States 814 Quince Orchard Blvd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Meiseles Gerhardt Hepner မ a. Informant's Name/Relationship *(Type. Print)* Allen Hepner, Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $14304\ Crazy\ Quilt\ Ct.,\ Boyds,\ MD\ 20841$ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Judean Memorial Gardens 09/28/10 5 Other (Specify) Olney, MD 4 Donation ral Sarvice Licensee Torerrsky steemen Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Recurrent Metastalic Gastroniesting **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events at this industrial death). Examine Due to (or as a collisequence of) The law requires that the death certificate be exacured as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Day for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the at detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signe page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 🗆 No 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, director. Be examiner? Hospital: 1 X Inpatient Other: 4 - Nursing Home 2 X No 2 ER/Outpatient 3 DOA 1 Yes 5 Residence မ this completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation After 1 💢 Natural (Month, Day Year) Injury 1 🗌 Yes 2 No after death. 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 24 hours a Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Within 2 To the F the

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31. Date filed (Month_Day, Year) ---State SEP 28 2010 Registrar

29b. Signature and title of certifier

one)



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Soares

29c. License number

RES-000

September 26,2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Albert Abraham Hahn 2010 September 6:58 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Mar 7, 1936 1 X M 2 - F Mary Land **Director** 215-36-6388 74 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Frederick Sabillasville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17351 Sunshine Trail 21780 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Nes 2 No 1975-If Yes, Give 1986 Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 1986 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Frederick_Co Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Luther Hahn Ida Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Hahn, wife 17351 Sunshine Trail, Sabillasville, MD 21780 20b. Place of Disposition (Name of cemetery, crematory or other placem Fountaindale Union 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/24/2010 Fountaindale, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ TEMORRITAGIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** TLLE LERATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ASPIRATION Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical ESPIRATOR Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTORIT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No injury Natural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contribying Nurse Practioner: To the basis of yellow body doubt accounted at the first debt and does not deliber to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number

WHSTIVA

Registrar
DHMH 17 Rev 7/2009

State

G.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-WIRDY

32. Pegistrar's Signature

ALYAKO

31. Date filed (Month, Day, Year) SEP 2

0062006

ANTETAM

ST. HAAGUSTOWN MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 18, Day 2010 Year 3:35 Ам Elizabeth Githens Humphreys Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Lutheran Village Healthcare Westminster 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
 Secuntry) 8. Date of Birth Funeral Days Hours July 26 Year) 1919 1 □ M 2 😾 **Director** 177-14-7477 Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 Yes 2 No Carroll MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21158 U.S.A. 300 St. Luke Circle 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 ☑ No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No White Specify. Specific Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last, Frank W. Githens 18 Mother's Name (First Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Old New Windsor Pike, Westminster, MD 21157 Joan MacDonald - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremations Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9/21/2010 Hampstead, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lipersee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter pt. disease, or complications medical each be death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Yes No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completed filled in by the funeral dir Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury al Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioger: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WSI

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Year

32. Registrar's Signature

			For State Registrar	State of Maryla	nd / Depa		lealth and M	lental Hyg	•	32063
132	Physicia /Medic		1. Decedent's Name (First, Middle, Las Ung Kwon					2. Date of Deat Month Sept. 2	th 2010 Year	3. Time of Death 5:30aM
1	Examin	w &	4a. Facility Name (If not institution, give Fairland Nurs				r Location of Death er Sprin		4c. County of Dead	
	Funeral Director		5. Social Security Number 6. S		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 3 / 05 / 19	9. Bin S ^{Co}	hplace (State or Foreign or Rorea
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Md Montgo		City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 12630 Viers M	ill Road		10f. Zip Code 208	53	1	0g. Citizen of What Co	
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	vithin 72 ho ne. han "natur e Medical I	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		dent's Usual Occup to kind of work done DO NOT use retire uto Mec	pation during most of work d) hanic	king	16b. Kind of Business. Automok	
land 2	12 should be filed within "h and Mental Hygiene." is marked other than "fraumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, Last) Moon Bin Kim						Maiden Surname)	
, Maryland	and 2 shou ealth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Peter Hyeon/S	Type. Print) ON	19b. Maili 517	ng Address <i>(Street</i> Bonifa	and Number or Bu nt Road	ral Route Number Silver	r, City or Town, State, Spring , I	70 9 0 4
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghen. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removal from State	Gate o	osition (Name of matory or other pla I Heave	ຕ [ຶ] 9/22	2/2010		Spring, Md EE, P.A. ng, Md20910
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	plications that caused the de one cause on each line. Atherosc. a. Due to (or as a cons Hypertens b. Due to (or as a cons	eath. Do not en leroti equence of): sion	ter the mode of dyi	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death 6 MO •
68760,	death certificate be executed eath certificate be extending physician and d for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):				V	
. Box	death e atten d for u	Physician/Medic	!F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	sy		23d. Date of de Month	elivery Day Year
ds, P.0	requires that the de een signed by the a rould be detached f	by	Part II. Other significant conditions of	contributing to death but not r	resulting in the ι	underlying cause gi	ven in Part I.		bacco use contribute t	o the cause of death? Probably 4⊠Unknown
I Records,	aw as bi	Completed						24a. Was a autop perfor 1∐ Yes	an 24b. Were a prior to death? 2 1 □ Ye	uutopsy findings available completion of cause of s 2 □ No
or Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	I E E P (Outrotio	ent 3□ DOA Ot		th Check onl or	ne lence 6 □Other (Sp	
ion or	ing Phy After this uneral d	ation: To	27. Manner of Death 1 Manual 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of	of 28c. Inju			ow injury occurred	өспу)
Division	pital or Attendurs after deathurs after deathurs aral Director: , silled in by the f	Certification:	3 Suicide 6 Could not b determined		ecify)			City or Tow		
	the Hospital hin 24 hours a the Funeral upletely filled	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	miner: On the basis of exam and manner stated.	nination and/or i	nvestigation, in my	opinion, death occu	urred at the time,	date and place, and du	ue to the cause(s)
	To the within to the comp	M	29b. Signature and title of certifier				se number 8656	2	29d. Date signed (Mor Sept.21,	
			30. Name and address of person who Ravi Passi M 31. Date filed Month Day, Year	D. 15245	Shady		d Rockv	ille,Md	1. 20850	

Registrar DHMH 17 Rev 1/2001

State

SFP 27 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 2010 7:07 pM MARTBEL_TZURTETA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY INSTITUTES OF HEALTH BETHESDA NATIONAL Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Ecuador (Month, Day, 03 ___18 1 - M 2 X Months Days Hours Min. Director 1978 none Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No Quito Ecuador South America 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral none Calle El Ingenio Lote F-05 Ecuador 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Ecuador If Yes, Give Year or Dates Specify: Hispanic 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)
4 Years Elementary/Seconday (0-12) Marketing Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eduardo Izurieta Maria Araujo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calle El Ingenio Lote F-05, Quito Ecuador Luis Fradejas/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/24/2010 | Alexandria, VA Metropolitan Crem. 21. Signature of Fun-22. Name and Address of Facility Marshall March Funeral Home Service Licenses 4217 9th Street NW, Washington, DC 20011 MAN A 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alveelar disease or condition ن لار Medical resulting in death) Due to (or as a consequence of): Examiner somete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Multid Cause (Disease or iinjury that initiated events mich Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed?

Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Hospital 2 🗹 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 23/10 MA 233990 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20982 PARITOSH PRASAD 31. Date filed (Month, Day, Yea. State 27

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ **23** ÍÖ Chauncey Harold Jones Sr. 12:46 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5212 Kenmont Rd. Oxon Hill Prince George's . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Year) Country) Director 74 Vrs <u> 577-44-8774</u> Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Oxon Hill 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5212 Kenmont Rd. 20745 AZU 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 2 1 No 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Specify: **Black** the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Ь Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ned Jones Sarah Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 Kenmont Rd., Oxon Hill, MD 20745 Carletha Jones / daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Marvland Veterans Cem; 10/04/2010 Cheltenham, MD 21. Signat (re) 1 Funeral Sept Ce Licen 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a cons-Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month ☐ Pregnant at time of death ☐ Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performe Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical B 26. Place of Death (Check only one) 1 X Yes 2 No ည 24 hours after death.
Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify funeral . Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injur, 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only of Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. License number State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 Robert Anthony James 0702 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO TENINSULA REGIONAL MEDICAL Center SAUSBURY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** MD Country) Days 1 🛛 M 2 🗆 F Months Hours Min (Month, Day, Year) 86 Director 194-18-0772 Usual Residence of Decedent show 10a. State 10b. County death with the Maryland 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 √ Yes 2 ☐ No MD Somerset Princess Anne 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 29856 Deal Island Road 21853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 9 þ 1 Yes 2 X No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates "natural", Speci**Black** 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working State of permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Massachusetts Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Annie Maddox Clinton James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver Hearne/Cousin 30514 Pecan Drive, Princess Anne, MD21853 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Cometery, crematory or other place) 20c. Location - City or Town, State Direct Crematory, 10-5-2010 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) ervice Licenses ^{22. Name and Address of Facility} 917 W. Isabella St. Bennie Smith Salishury, MD 21801 Funeral Home Salishury, MD 21801 23a. Part 1. Enter the disease or complications that cause shock, or heart allure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) day Sepus Medical Due to (as a consequence of): Examiner tract infection Drivary Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a cons y uence of): Examir or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural (Month, Day, Year) 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation the Suicide 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License numbe

State

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HOFMAN

30. Name and address of person who com

31. Date filed (Month, Day, Year)

B.

MOUNT

d cause of death (Item 23a) (Type, Print) 30434

P0059931

PRINCESS ANNE.

			For State Of Mary 1- State Registrar		rtificate of		R	leg. No.	
1	Physic		Decedent's Name (First, Middle, Last) Oneida Armacost Jones				2. Date of Dea Month Septem	Day	3. Time of Death 2010 10:30 P M
	/Medi Exami		4a. Facility Name (If not institution, give street and number) Long View Nursing Home		4b. City, Town, o	r Location of Death	Борсан	4c. County	of Death
* (.	Funeral Director		5. Social Security Number 219-05-1814 Usual Residence of Decedent	yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Aug. 15	, Year)	9. Birthplace (State or Foreign Country) Maryland
	e Maryland la-f show tified at	ctor		c. City, Town or Lo Hampstea					10d. Inside City Limits 1 May Yes 2 ☐ No
	th with th 23a or 28 ist be no	Funeral Director	3815 Sunnyfield Court		10f. Zip Code 21074			10g. Citizen of N Inited S	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, 2 Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🂢 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	1	ce - American Indian, ck, White, etc. y: white
15-0	in 72 ho n "natur fedical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of working)	ng		usiness/Industry
1212	filed within Hygiene. ther than "ther the Mec		Elementary/Secondary (0-12) College (1-4or 5+) 12		ce worker				ial firm
lanc	uld be fi Mental H Irked ot Itic ever	To Be	17. Father's Name (First, Middle, Last) G. Marshall Armacost			18. Mother's Name Carrie F		maiden Surnan	ne)
, Maryland 21215-0036	and 2 should b ealth and Ment n 27 is marked ner traumatic e	Ŀ	19a. Informant's Name/Relationship (Type. Print) James R. Jones / son	19128	3 Longmea	and Number or Rura dow Road	Hagers	town, M	D 21742
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra once.				osition (Name of matory or other place s Cemete	i i	24, 2010		City or Town, State , Maryland
Bal	permit. Departi Imports any Inj.		21. Signature of Funeral Service Licenses	40-0	2. Name and Addre 34 South	11.	ine Fune et Ham		me Maryland 21074
5	tificate be executed By Physician and as the burial-transit as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	nsequence of):	ter the mode of dyir		or respiratory arr	rest,	Approximate Interval Between Onset and Death
68760,	tificate be g physicia as the bu		d						
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burtal-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,			ite of delivery onth Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	20	tribute to the cause of death?
al Rec	i: The law i icate has be r, page 2 sh	Completed by					24a. Was a autop perfor 1 Yes	med?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
or Vit	ding Physician: The lav n. After this certificate has funeral director, page 2	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury.	2 ER/Outpatier		4/1 Nursing Hor		ence 6 □Oth	ner (Specify)
Division or Vital Records,	or Atten after death Director:	Certification:	Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 5 □ Pending investigation 6 □ Could not be determined 6 □ Could not be determined 28e. Place of injury building, etc. (S	At home, farm, str	M 1□	Yes 2 □ No	28f. Location <i>(S</i> City or Tow		per or Rural Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.	y knowledge, deat mination and/or in	h occurred at the tire to the	ne, date and place, ppinion, death occurr	and due to the c	cause(s) and madate and place,	anner as stated. and due to the cause(s)
	MIL	M	29b. Signature and title of certifier Burnshiya, MD		D 5	1705	. 2	29d. Date signe	d (Month, Day, Year)
	<i>6</i>		30. Name and address of person who completed cause of death M. PANSURIYA 2111 Heave	LOVEL	Piko.	Heim	poteas	2, M	121074
DI	Sta Regist	rar	31. Date filed (Month, Day, Year) SEP 2 1 2010 Lenum	J. A.	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:08 P M 2010 September 16 Patrick Joseph Jose 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Anne Arundel Severna Park 146 Boone Trail If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 X M 2 □ F 86 080-18-1169 New Jersey April 01,1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 146 Boone Trail USA 12. Was Decedent Ever in HS Armed Forces? WWII 1 MYes 2 □ No Korean If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Armed Calvary U.S. Army 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Jose Helen Capra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michaela Henrietta / Daughter Brabanter Str 15 80805 Munich, Germany Date 23, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 2010 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD Barranco & Sons, 495 Ritchie Hwy, 21. Signature of Funeral Service Licensee P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2008 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of) H per tension resulting in death) Last 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No. 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 \(\subseteq \text{ Nursing Home} \) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident

the death certificate be executed burial-tran and physician s the burial Box 68760, attending p P.0. been signed by the should be detached Division of Vital Records, page 2 this certificate Physician:

After

To the Hospital or Attending

Examiner Physician/Medical þ Completed Be Certification: To funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Director

by Funeral

Completed

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Funeral

Director

show

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in than "natural", or Items 23a or 28a-f show the Medical Examinations by notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, Item Medical Examine critical once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical

5 Pending investigation

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 Homicide

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARM RD.

ENINSULA

6 ☐ Could not be

determined

DAGBS,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ARNOLD MD

29d. Date signed (Month, Day, Year)

Medical

1081 State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

FARM

Registrar

10-07330

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gia James	F	- For State Registrar		of Maryla		ertificate o		nd Menta		Reg. No. 20	0 3208	59
Physician Medical Examine		1. Decedent's Name Gia	(First, Middle,La James	st)					2. Date of De Month Septemb	path Day Year Der 23, 2010	3. Time of Death 1900 hrs	
		4a. Facility Name (if PG Hosptial	not institution, gi	ve street and nur	nber)		4b. City, Town, Cheverly	or Location of E		4c. County of Prince Ge		
Funeral Director		5. Social Security No. 215-98-91	umber 6. S	ex M 2 X F		last birthday)	If Under 1 Ye		Min.	lirth(MM/DD/YYYY)	Birthplace (State or Foreign Country)	
	-	Usual Residence of	Decedent						шес	11, 1900		
d bow any	Ι,	Maryland	Prince	Caorga t		y, Town or Loca		. Raini	er		10d. Inside City L	
the Maryland a or 28a-f show		10e. Street and Num		George .	2		10f. Zip Code			10g. Citizen of What	t Country?	
th the land the land the land title land to land the land title land land land land land land land land		3425 New	ton Str			1.0		20712			States	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once TO Be Computated by Eimoral Director	nuer	11. Marital Status 1 Never Marrie	d 2 Married	12. Was Dece Armed Fo			as Decedent of F Yes, specify Cub		? (Specify Yes or Nuerto Rican, etc.)	14. Race - White,	American Indian, Black, etc.	
s after d		3 X Widowed		d If Yes, Give Year or Dates:			Yes 2 X N			Specify:	Black	
72 hours "natu		15. Decedent's Edu Elementary/Secon		only highest grad College (1-			nt's Usual Occup nost of working li			16b. Kind of Busin	ness/Industry	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Example Completed				3		Direct	or of Me				ivate	
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica		17. Father's Name (F		H. Gray	,			ľ	Name (First, Middle) Cynthia	Maiden Surname) Thomas		
hould b nd Men is mar		19a. Informant's Nar	me/Relationship (Type, Print)		1		eet and Number	r or Rural Route Nu	imber, City or Town,		
and 2 s fealth a fem 27 traum	ŀ	Monique (20a. Method of Disp		- Sister	20b	. Place of Dispo	sition (Name of c	emetery,	Washingto Date		0019 City or Town, State	
Baltimore, permit. Pages I a Department of He important: If ite injury or other to	1	1 Burial 2 4 Donation 5	Cremation 3 Other Specify		m State	crematory or c	_{ther place)} Cremator		Sept. 28, 2010	Clint	on, Marylan	ıd
Saltil ermit. Departm mporta	t	21. Signature of Fun			- 17	22.	Name and Addre	ss of Facility	Stewart F	uneral Ho		
Physician	+	23a/Part I. Enter the	disease, or com	DU QUE	used the deat	h. Do not enter	001 Benn the mode of dying	ing Roa g, such as card	ad NE Was liac or respiratory a	hington, I	t Approximate Int	
Medical Examiner		Immediate Cause (F		ach line. Coronary A	tery Thron	nbosis					Between Onset Death	t and
	-	or condition resulting	h	Due to (or as a Atherosclere		•	sease					
ig		Sequentially list con if any, leading to imr cause. Enter Under	mediate	Due to (or as a	consequence	of):						
ted Insit	LXall	(Disease or injury th events resulting in d	leath) Last	Due to (or as a	consequence	of):						
execuian and ial - tra	<u> </u>	UNPENDED	a	AMENDED		-						
Box 68760, e death certificate be the attending physic ed for use as the burker of the		IF FEMALE: 3b, Was decedent p	pregnant in the	23c. If yes, o			atal daath 3	Ectopic pr	egnancy	23d. Date of de Month	elivery Day Year	
box 6876. The death certificate the death certificate by the attending phyche for use as the Dhyceinian M.		past 12 months?	,	4 Pregna	int at time of c	looth —	etal death 3 other (Specify)		egridiney	Wioria	Day 10a	
<u> </u>		Part II. Other signifi		9 Unkno		resulting in the	underlying cause	given in Part I.	. 23e. Did	tobacco use contribu	ute to the cause of death	1?
- S 60 6									- 1		Probably 4 Unkno	
Records, The law requirer ficate has been significate has been significate has been significate has been significated.				_					24a. Was	psy pric	ere autopsy findings avai or to completion of cause ath?	
Rec		25. Was case referre	ad to modical			_	26 Plac	ce of Death (Ch	1 ✓ Yes		Yes 2 N	0
f Vital Physician rr this certi ral director	۱۵	examiner?		Hospital: 1 Ir	patient 2	ER/Outpatier		Other:	ursing Home 5	Residence 6	Other:	
4-A 55'		27. Manner of Death 1 Natural	5 Pending	28a. Date of (Month,	of Injury Day,Year)	28b. Time of		ury at Work?		how injury occurred		
Division o spital or Attending nours after death. neral Director: Afti filled in by the fune	<u> </u>	2 Accident 3 Suicide	Investigat	28e Place	of Injury - At I	home, farm, stre	eet, factory, office	-			or Rural Route Number,	, City
hou big		4 Homicide	determine	1-237								()
Divis To the Hospital or 4 within 24 hours after To the Funeral Direction of completely filled in bundling Contribit	a calca	(Check only			examination	-				ise(s) and manner as a and place, and due		
- 4.2 £ 8 2	ME	29b. Signature and t	itle of certifier	A				nse number			(Month, Day, Year)	
		30. Name and addre	man	W)	of doath /lt-	m 23a\	0.0	.M.E.		September 2	.4, 2010	
R 4		Laron Locke	•	tant Medical			n Street, Balt	imore, MD 2	21201			
Stat Registra	te ar	31. Date filed (Month	2010 Z	32. Reg	gistrar's Signa	ture and						

ORIGINAL

10-07475 Elizabeth Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Please Type or Print in Black indelible ink. Ensure All Copies Are L						
State of Maryland / Department of Health and Mental Hygiene		201	8	321	77	
Certificate of Death	Rea No	L 0 1		·		

		1- For State Certii Registrar	ficate of Death	Reg. No	2010	
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exami	iner	Elizabeth Teresa Johnso		Month Day September 29	c. County of Death	0920 hrs
)		4a. Facility Name (if not institution, give street and number) Doctor's Hospital	4b. City, Town, or Location of Death Lanham		c, County of Death Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		_ ` 1	/DD/YYYY) 9. Birt	hplace (State or Mashingto
Director		066-56-1143 1_M 2XF 47	Yrs. Months Days Hours Min.	December	31, Co.	D. C.
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location			10d. Inside City Limits
* "			reenbelt			1 X Yes 2 No
urylanda sa-f st	cto	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Cour	itry?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or items 23a or 28a-f sho is rother traumatic event, the Medical Examiner must be notified at once.	Director	7819 Mandan Road; Apt. 304	20770	1	Jnited St	ates
with ns 23; be no	uneral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp		14. Race - Americ	can Indian, Black,
death or iter must	E C	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after ral", c	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:			lack
hours 'natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		Kind of Business/I	ndustry
36 nin 72 E. than '	Completed	12th grade	Store Manager	Do	ollar Tre	e Stores
21215-0036 21215-0036 Juld be filed within 7 I Mental Hygiene, marked other than ic event, the Medica	ě	17. Father's Name (First, Middle, Last)	•	(First, Middle, Maider		
215 be file stal H. ked o	BB	Arthur King	Lena	Johnson		
e, MD 21215-00; I and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other tilter traumatic event, the Med	ဥ		19b. Mailing Address (Street and Number or F	•	•	
MD and alth and as 27 is summati			5011 Quell Court; Wood	lbridge,Vii	rginia 22 Location - City or	193
			ice of Disposition (Name of cemetery, imatory or other place)	Date 20c.	Location - City or	Iown, State
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5 Other Specify: Line	coln Memorial Cemetery	Sı	itland,	Maryland
Balti permit. Departm Imports injury o		21. Signature of Funeral Parvice Licans	22. Name and Address of Facility R.			
	5	23a. Part I. Enter the disease, or complications that caused the death. Do	Inc.; 600 Kennedy S			ton, D.C. 20 Approximate Interva
Physician /Medical		failure. List only one cause on each line	nd dilated cardiovascu			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive a: Due to (or as a consequence of):	nd dilated Cardiovasco	ital disea.		Death
		Sequentially list conditions, b	•			
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last				
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BOy death the att	Physician	1 Yes 2 No 9 V Unknown 9 Unknown				
that the red by the	by PI	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.			he cause of death?
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w requires the should be a sho	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
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tal Rectian: The certificate ector, page	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check of	only one)		
dire his	P	1 Yes 2 No No Inpatient 2 Y EF			ence 6 Other:	
> \$ 4 g		1 X Notural (Month, Day, Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe how inj	ury occurred	
n of V ding Phy After th funeral d	ାଧା	rending	1 Yes 2 No	206 1	and Manager and Disc	al Davida Number Cit.
Sion of V Attending Phy death. sctor: After th	cation				and Number or Rur	al Route Number, City
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaoled in by the funeral director, page 2 should be detaoled.	ertification	3 Suicide 6 Could not be determined (Specific)	e, farm, street, factory, office building, etc.	or Town, State)		
Division of V Hospital or Attending Phy 24 hours after death. Funeral Director: After th tely filled in by the funeral	al Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home			nd manner as state	d.
Division of V o the Hospital or Attending Phy idihin 24 hours after death. o the Funeral Director: After the ompletely filled in by the funeral		3 Suicide 6 Could not be 4 Homicide determined (Specify) 28e. Place of Injury - At home (Specify)	death occurred at the time, date and place, and	due to the cause(s) a		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Certification	3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, and for investigation, in my opinion, death occurred a 29c. License number	due to the cause(s) at t the time, date and pl	ace, and due to the	th, Day, Year)
Division of V To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral of		3 Suicide 4 Could not be determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	death occurred at the time, date and place, and for investigation, in my opinion, death occurred a	due to the cause(s) at t the time, date and pl	ace, and due to the	th, Day, Year)
Division of V To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral of		3 Suicide 4 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/one and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23)	death occurred at the time, date and place, and for investigation, in my opinion, death occurred a 29c. License number O.C.M.E.	due to the cause(s) at t the time, date and pt 29d. Sep	ace, and due to the	th, Day, Year)
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10-07190 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 32071 Dwayne Louis Jones State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 0720 hrs DWAYNE LOUIS JONES September 18, 2010 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Deat Montgomery 9315 Stewartown Lane Gaithersburg 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Director 214-82-2275 48 1X M 2 F 07/08/1962 Country) MD Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Howard Mount Airy Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 1120 Shaffersville Road 21771 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Black Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Moving Company 12th Mover and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annabelle V. Dorsey John Lawrence Jones ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health and M at: If item 27 is m other traumatic e 9413 Merust Lane, Gaithersburg, MD 20879 Deborah D. Jones - wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, 1 X Burial 2 Cremation 3 Removal from Stat Department o
Important:] 09/27/2010 Mt. Airy, MD Simpson UMC Cemetery 4 Donation 5 Other Specify 22. Name and Address of Facility Snowden Funeral Home onature of Funeral Service 246 N. Washington St, Rockville, MD 20850 ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart omplications that caused the d Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last tttending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? page Yes 2 V No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 funeral 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject hanged self 1 Natural **FOUND** Division 1 Yes 2 ✔ No 5 Pending the Sep 18, 2010 0710 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 9315 Stewartown Lane, Gaithersburg, MD determined (Specify) Yard 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: Twithin 24 hours after death.
To the Funeral Director: After this certific

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner

32 Registrar's Signatu

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 19, 2010

State Registrar

within 2 To the I

29b. Signature and title of certifier

tinbar toley

32. Degistrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

September 28,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11, per Fh 9908 10/27/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 201 WARREN 12 48 EARL KILPATRICK October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Months Hours 549-34-2195 85 Nebraska Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Frederick Frederick 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 5734 Box Elder Ct. 21703 United States items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Statue 14. Race - American Indian, Armed Forces? Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Xwidowed 4 ☐ Divorced 1944 Bal 948 "natural", 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) US Government ectrical engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abraham Lincoln Kilpatrick Mary K. Kafka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19730 Frog eye Rd., Knoxville, Md, 21758 Ed Kilpatrick (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem 10/7/2010 Silver Spring, Signature of Funeral Service Licensee Keenevodes Bestord P.A. Funeral Home any 21701 106 E. Church St., Frederick, Md., MO161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner unknown Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to of as a consequence of) The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown q Unknown Division of Vital Records, P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 유 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 🗹 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick 31. Date filed (Month. Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Amend#5perfuneralhome10/7/2016/16/16/16/16/16 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sept Marv Alice Kennedy 5:38_A_M^M Medical 4a. Facility Name (if not institution, give street and number)
6006 Melbourne Ave Examiner 4b. City, Town, or Location of Death 4c. County of Death Deale Anne Arundel If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) Jan 24, 1924 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XXF Months 86 Washington DC 578 20 9329 9327 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shor Examiner must be notified at 10a. State with the Maryland Director 1 Yes 2 No Deale Maryland Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6006 Melbourne Ave 20751 United States permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: White Specify: "natural", 3 XWidowed 4 Divorced Year or Dates of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bank Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabel Estelle Riston Chas Leekron Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Melbourne Ave, Deale, MD 20751 Wm W. Kennedy, Jr. (son) Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Oct 6, 2010 Cheltenham, Maryland . Sign tu of Funeral Viol Line 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 6 disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death ed by the a g Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{A}\) Residence 6 \(\sum \) Other (Specify) 2 17 100 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suici**d**e 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) Old Solmans Island Rd use of death (Item 23a) (Type, Print) 30. Name and address of person who completed c h 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 24, 2010 Physician/ 6:30 A M Viola F. Kuchinski Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c, County of Death Examiner Prince George's 1417 Quinwood Street Hyattsville 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Social Security Number **Funeral** (Month Day, Year) 8 Months Days Hours Min. Pennsylvania **Director** 203-01-5483 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince George's Hyattsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1417 Quinwood Street 20783 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3X Widowed 4 □ Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Switchboard Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Stephanovitch Adolph Walcavich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hyattsville, Maryland 20783 Karin L. Harris/daughter 1417 Quinwood Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Carcemation 3 Removal from State Hinal Journey Crematory 9/28/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD Signature of Funeral Service Licensee Juanita R Thomas M00957 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Senile Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 🗷 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Hypertension Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia autopsy performed' 1 ☐ Yes 2 🛛 N Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛣 Natural 5 Pending work' 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are the cause of the cause 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058290 September 24, 2010 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

Box 68760

P.O.

Division of Vital

State Registrar Suresh K. Muttath,

M.D.

32. Registrar's Signature

5711 Sarvis Avenue, Suite 200 Riverdale, Maryland 20737

10-07271 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gurumeher Singh Khalsa 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Y September 21, 2010 1610 hrs Medical Examiner Meher Singh Khalsa Guru 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rethesda Montgomery Surburban Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Foreign Months Hours Days Director 229-59-2197 1988 Country) Virginia 1 XM 2 F 22 Mar 16, Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Maryland Montgomery Silver Spring permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho items 23a or 28a-f shoust be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? 9130 Walden Road 20901 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married Yes 3 Widowed White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Student Education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be <u>Bhagwant</u> Khalsa Rose Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Khalsa/mother 9130 Walden Road Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c, Location - City or Town, State Date Baltimore, or other t crematory or other place) 1 Burial 2 X Cremation 3 9/27/2010 inal Woodbine, Maryland Journey Crematory Qonation 5 Other Specify 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly 1. Heckrotte, P.A. Clarksville, M ignature of Funeral Servi M00957 MD 21029 Manie nomao Rat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. ner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnance 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ⋧ ۵. 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed' 1 🗸 Yes 2 No certificate ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 Nursing Home 5 Residence 6 Other: DOA this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: FOUND After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification FOUND: Subject shot self Natural Division 1 Yes 2 V No Pending hours after death. Funeral Director; Sep 20, 2010 2000 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 809 Stirling Road, Silver Spring, MD (Specify) Single Family Home Homicide

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within 2 To the Medical

State Registrar 29a. Certifier 1

29b. Signature and title of certifier

Ling Li, MD 31. Date filed (Month D and manner stated.

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

111 Penn Street, Baltimore, MD 21201

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

29d Date signed (Month, Day, Year)

September 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ctober Physician/ W. Lipscomb Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland 9. Birthplace (State or Foreign Country) WV 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Funeral 1 **≰** M 2 □ F *`*Mov?23°. 58 Director 218-60-0493 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 XYes 2 No Cumberland MD Allegany 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 127 Gleason Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 🔽 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. Completed 3 Widowed 4 Divorced Year or Dates white 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wallpaper Hanger Wallpaper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Wavne W Lipscomb Mayetta (Carr) Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 127 Gleason Street Cumberland Sister Mary Self 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 10/7/2010 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Park MDCumberland 21. Signature of Funeral Service Licensee 22. Nam Scanselff Puffer al Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ENDSTAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a betached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SZCONDARY to LOCOCONS 2 No 3 Probably 4 Unknown 1 \square Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 2LO PESPASS within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 seconpleted filled in by the funeral director, page 2 seconpleted filled in by the funeral director, page 2 seconpleted filled in by the funeral director. performe death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ျ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Robustiano Barrera

31. Date filed (Month, Day, Year)

M.D

32. Red

200 Glenn St. Suite 200 Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ 4:20 PM 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** ALTIMORE MEMORINI If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yea 1 🗆 M 2 🗹 Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: MITE 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALVATORA BRANHAM. 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition matory or other place) BROOKLYN PARK, MD. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State -3-10 4 Donation 5 Other (Specify) nei 21. Sign Service 2601 MOUNTAIN RD. DASADEN 23a Fart 1. Enter the disease, hock, or heart failure Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) renal days Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury marth After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit vanced that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Months Hospital or Attending Physician: The law requires that the death certificate be Carree Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 → robably 4 □ Unknown 2 🗌 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗐 No 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after death To the Funeral Director: / completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number was, MD 2438946-029 129/10 Joan

State Registrar atal 201 E. University

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Mamoria

32. Registrar's Signature

Greaced

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month Day

27 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item - State Registrar #16a, per fh, 9/29/10 ca Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VITO PHILLIP LOMBARDO 26,2010 Sept /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomic Salisbury Rehabilitation & Nursing Ctr. 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Hours Months 113-28-5420 73 **Director** NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Matcal Examiner must be notified at Director MD. SOMERSET CRISFIELD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 SOMERS COVE, APT. 21817 Funeral UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ₩Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT INSTAULLER INSTALLER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi h and Mental FELICE LOMBARDO JOSEPHINE LOMBARDO P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. CONNIE MILLER DAUGTHER 30897 EDEN ALLEN RD. EDEN, MD. 21822 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory 9-29-10 Salisbury, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINMAN FUNERAL HOME M00295 11673 SOMERSET AVE. PRINCESS ANNE, MD. 21853 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In ediate Cause (Final disease or condition resulting in death) Physician -paz-/Medical Due to for as a consequence Examiner Day Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No by the 9 I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No neral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar		1arylan		artment of F			Reg. No		32083
	Physicia /Medic		1. Decedent's Name (First, Middle, Carolyn Lynette	e Lynch					2. Date of Month Sept.	25,	2010	3. Time of Death 7:00 A ^M
	Examin	er	4a. Facility Name (If not institution, 6605 Killarney		r)		4b. City, Town, o		eath		ince Geo	
	Funeral Director		5. Social Security Number 579–72–6782		nge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F	lin. 8. Date of (Month) July	Birth , Day, Year)	9. Birth	place (State or Foreign untry) Ch Carolina
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince	Coorgos		y, Town or Lo	cation					10d. Inside City Limits 1 □ Yes 2 ☑ No
adt the	h with the l	al Director	10e. Street and Number 6605 Killarney	Georges Street	CII	iicoii	10f. Zip Code 20735				tizen of What Cou USa	intry?
030	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show dical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? ≬ No	ļ	Was Decedent of H If Yes, specify Cub		(Specify Yes or lerto Rican, etc.	No-	14. Race - Amer Black, White Specify: Blac	, etc.
9500-6171	be filed within 72 hours ital Hygiene. id other than "natural" event, fre Modical Exe	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or	5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of v d)	working		ind of Business/li	ndustry
ם ש		To Be Co	12 17. Father's Name (First, Middle, L Curtis Outlaw	ast)		Stall	Assistar	18. Mother's N	Name (First, Mic Lhy Mae	ldle, Maiden		. <u>-</u>
Ĕ	nd 2 salth ar 27 is rrtrau		19a. Informant's Name/Relationsh Herman L. Lynch	, , , ,		6605	ng Address (Street Killarney	st., C	Clinton,	MD 2	0735	
.	Page: nent o nt: If i		20a. Method of Disposition 1	ecify)	e	hingto	sition (Name of natory or other place on Nation	al 9/	Date 30/2010		ocation - City or T	
	Permit Departing		23a. Party Enter the disease, or of the k, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	< Yohns	in C	6 h. Do not ent	2. Name and Addre	Branch A	Ave., Te	mple		Home P. A. D 20748 Approximate Interval Between Onset and Death 18 Months
	infrate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter this entitle Cause (Disease or injury that initiated events resulting in death) Last	b								
O. BOX 60/	To the hospital of Attending Physician: The law requires that the death certificate within 24 burous after during the within 24 burous after during the standard of the Funeral after this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Feta	Ideath 3	Ectopic pregnand	су			23d. Date of deli Month	very Day Year
rds, r.	quires that the signed by all the detaction	by P	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying cause giv	ven in Part I.			. /	the cause of death?
II Records	re law recate has bee	Completed							— а	Vas an lutopsy erformed? es 2 A No	prior to c death?	topsy findings available ompletion of cause of
VIII :	sician: certifii rector,	Be	25. Was case referred to medical examiner?	Hospital:			oth		Death (Check or	-		
VISION OF	nding Physith. : After this e funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, E	jury	28b. Time of Injury	28c. Inju	4 □ Nursin ry at	* **	Residence ibe how inju	6 ☐ Other (Spec ry occurred	ify)
SINIO :	tal or Attel rs after des al Director led in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place of it	njury - At ho etc. (Specif	ome, farm, str	eet, factory, office		28f. Locatio City or	on (Street ar Town, State	nd Number or Ru e)	ral Route Number,
:	the Hospi hin 24 hou the Funer npletely fill	Medical	(Check only 2 Medical E	g Physician: To the bes xaminer: On the basis and manners	of examina		vestigation, in my	opinion, death o		me, date an	d place, and due	to the cause(s)
	To To Con	2		anmo			D H	7 654		29d. Da	Resigned (Month	n, Uay, Year)
R	15		30. Name and address of person v	pho completed cause of M	death (Iten	10 II	VINA 5	H. NW	, Wash	ingto	n, DC.	20010

State Registrar

Several B. Market 31. Date filed (Month, Day, Year) SEP 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Josephina A. Layman Рм 2010 3:05 September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8221 Garland Avenue, Apt. #202 Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days (Month, Day, December Months Hours Min 1 □ M 2 🖾 F Guatemala 578-66-7361 78 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director 1 X Yes 2 No Takoma Park Montgomery Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 USA 8221 Garland Avenue, Apt. #202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Guatemalan Specify: Hispanic "natural" Completed 3 Nidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Cosmetologist 3 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Paula Argujo (Unav.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2025 Luzerne Avenue, Silver Spring, MD 20910 David Giron / Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/29/2010 Crownsville, Maryland Maryland Veterans Cemetery 4 Donation 5 Other (Specify) 4739 Baltimore Avenue 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or imjury that initiated events Due to (or as a consequence of) -transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) |w resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Day cate has been signed by the page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 2 \square No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner/ to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifier 2 nlx one) ure and title of certifie 29d. Date signed (Month, Day, Year) 29b. Sia 2010 ME Ke 5 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 10:12 A Susan Lowe Sep. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis 826 Coachway 8. Date of Birth (Month, Day, Mar.10, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 🗆 M 2 🖵 F Virginia 1949 225-64-7543 61 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director Annapolis Anne Arundel Maryland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a United States 21401 826 Coachway items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. white "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 P h and Mental Hygiene. 7 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Beauty Aesthetician $\mathbf{B}^{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Meixner ၉ Leeland Blehm ige 1 and 2 should by nt of Health and Mer t: If item 27 is mark 9b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 826 Coachway, Annapolis, MD 21401 19a. Informant's Name/Relationship (Type, Print) Dr. David Lowe, Husband Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Hamportant: If ite any injury or ot King David Memorial Garden 09/29/10 1 X Burial 2 Cremation 3 X Removal from State Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) Torchinskyshebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause or each line. Approximate terval Between hset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director: Dane 2 should be death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title MI 10 s of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2010 Susan Frances Lanir 1512 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 X F Months Days Hours Min 0871071942 Director 109-34-4634 68 Yrs New York Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No Silver Spring Maruland Montgomery ō 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1111 University Blvd., W. #12 A-A 20902 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. the Medical Examiner Black, White, etc. ŏ Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Year or Dates Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Social Work Therapist other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bertha Fuerstein Arthur Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is 1111 University Blvd., W. #12 A-A, Silver Spring, MD Alon Lanir - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Garden of Remembrance 09/29/2010 | Clarksburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Aspiration Asphuxia Medical Due to (or as a consequence of): Examiner Alzheimer Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or the a consequence of) e attending physician and ed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cachexia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Arteriosclerotic Cardiovascular Disease s, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Malnutrition 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed?

Yes 2 X No death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ္ 1 ☐ Yes 2 💢 No 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending X Natural Accident Suicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

1500 Forest Glen Road.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

28 2010

Shailesh Sheth.

Date filed (Month, Day, Year)

5250

Silver Spring.

2010

Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician rene 6 One 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Courrol aneytow orien laner OWO If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Hours Days 1□M 2**X**F 16, 1949 220-52-4221 61 May Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Taneytown Carroll Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 405 Cherry Oak Court USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: white Š Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir. Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Certified Nursing Assistant Nursing Home 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tina Moses Onico McKinney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard W. Long, husband 405 Cherry Oak Court, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place)
Westminster Cemetery 9/20/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Westminster, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy signed by the atter Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 1 Inpatient Certification: To this funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the 51

> State Registrar

30. Name and address of person who completed

29b. Signature and title of certifier

Westminster 32. Regietrar's Signature

ause of death (Item 23a) (Type, Print)

Ka.

29c. License number

H0061206

Tracie L. Ryberg,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15 am Ž010 Alberta Leishear September Annie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day,)
March 02 Days 1 □ M 2 🗓 F Director Maruland 577-24-2448 87 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 Y No Silver Spring Maruland Montgomery 10e. Street and Number 10g. Citizen of What Country? by Funeral U.S.A 14809 Pennsield Citcle. 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ James Herbert Johnson Carrie Lee Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Kaye Coursen - Daughter</u> 2417 Saint George Way, Brookeville, Maryland 20833 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 09/27/2010 Burtonsville, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). signed by the attending physician and d be detached for use as the burial transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Year 1 ☐ Yes ∠ ↓ 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No <u>۾</u>| 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSpice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

Diane Ruckert. 31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

K115108

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 09 27 2010 9:21 PM Marcia Gail Minissale /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner E1kton Elkton Care and Rehab Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. Days Months Hours 1 ☐ M 2 ☐XF 02/02/1942 Pennsylvania 68 Director 197-32-5749 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthan "natural", or Itama 23a or 28a-f ehow the Medical Examinet must be notified at 1 Yes 2 No Kent Galena Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21635 USA 14639 John Peel Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black White etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 Food & Beverage Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked eny liqury or other treumstic events. ie marked Roberta Benner Raymond Max Leitzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14639 John Peel Road Galena, Maryland 21635 Robert Minissale-husband Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Galena Cemeterv 10/02/2010 Galena, Maryland 21. Signature of Juneral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland Home 21620 Mous Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** OVARIAN CARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examiner certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. signed by the ettending physician Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy The law requires that the death Year Month Dav 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown should s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has bairector, pege 2 s. 2 No 1 Tes 1 ☐ Yes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this Director: After that in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. м investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier MD 9/23/12 D0065733 2 STREET, BLKNN, MD 21921 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,176 A EAST 147617 RAO V. PULA NARATANA m s 2010 Discuss 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 201 Michaluk 1215A^M 09 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Queen Anne's Sudlersville Safe Haven Manor 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 08/08/195 Days Hours 1 M 2 XF 58 Yrs Director 219-62-8992 Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🗓 No Queen Anne's Chestertown MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 27 is marked other than "natural", or items 23 traumatic event, the Medical Examiner must USA 212 Warwick Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc. ģ 1X Never Married 2 ☐ Married within 72 hours after Maryland 21215-0036 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other ti 12 Warehouse Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Sezak Anton Michaluk 1 and 2 should be the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 Woodrail Drive Millersville, Maryland 21108 Maria Greshko - Sister injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 09/28/2010 Chestertown, Maryland Cemtery Chester 22. Name and Address of Facility 21. Signature of Funeral Service Licens Helfenhein & Newnam Funeral Road Chestertown, Maryland Kick ase, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, o con shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician OLIOBLASTOM disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): |ŵ resulting in death) Last burialphysician s the burial Physician/Medical 68760 attending IE FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box (Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Day Month Year Pregnant at time of death Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 Ø No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) CARE HOME After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 @ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) udle completed cause of death (tem 23a) (Type, Print) 223 /hgh Street, CHes for Found Wed MA VII. 32. Red strar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			A FOI	partment of Health and I ertificate of Death	Mental Hygien	2010	32091			
	Physicia		1. Decedent's Name (First, Middle, Last) Marilyn H Mackley		2. Date of Death Month September		3. Time of Death			
	Medic Examin		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick		c. County of Death				
	Funeral Director		5. Social Security Number 6. Sex 1	Monthe Days Hours Min	8. Date of Birth March Dag Year,	1925 9. Birtl	hplace (State or Foreign IntryPA			
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits			
	the Mary or 28a-f e notifie	Funeral Director	MD Frederick Frederi 10e. Street and Number	Ck 10f. Zip Code	10g. (Citizen of What Co	1 ☑ Yes 2 ☐ No untry?			
	eath with ems 23a er must b	-unera	604 Mary Street 11. Marital Status 12. Was Decedent Ever in U.S. 1	21701 3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	SA 14. Race - Amer	ican Indian,			
9000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes, 2 ※ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto	o Hican, etc.)	Black, White	e, etc. ite			
Baltimore, Maryland 21215-0036	ithin 72 ho ene. r than "nal the Medica	Completed by	(Specify only highest grade completed) (Gi Elementary/Seconday (0-12) College (1-4 or 5+)	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) Homemaker	king 16b.	own home	ndustry			
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Division of Vital Records,	aw as	Completed			24a. Was an autopsy performed?	prior to death?	opsy findings available completion of cause of			
/ital	s certificate has b irrector, page 2 s	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 XER/Outpa	26. Place of Death (Chec						
on of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate I completed filled in by the funeral director, page	Certificate: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	e of 28c. Injury at	28d. Describe how inju		(1)			
Division	cal or Atters also al Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Star		al Route Number,			
	he Hospit in 24 hour he Funers ipleted fill	Medical	2ga. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in 3 Certifying Nurse Practioner: To the best of my knowledge.	vestigation, in my opinion, death occurred a	at the time, date and place	ce, and due to the c	ause(s) and manner stated.			
	To t To t		29b. Signature and title of certifier	29c. License number D 4795	29d. D	Pate signed (Month	, Day, Year) Zolo			
	5		30 Name and address of person who completed cause of death (Item 23a) (Type IBTE A - KAZMI, MD 814	29c. License number D 47951 e, Print) Toll House-Ave	Frederi	uc, Mn	21701.			
	Sta Registra	le ar	31. Date filed (Month, Day, Year) SEP 2 4 20 0 32. Registrar's Signature	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bessie Estelle Moore Sept 24 2010 10:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Prince George's Forestville 3506 South Forest Edge Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Virgina 6. Sex 8. Date of Birth Funeral (Month, Day, Year) Nov 22, 1912 1 M 2 XX Days Hours 97 Director 213 16 1028 Usual Residence of Decedent or 28a-f show 10a State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗆 Yes 2 📉 No Maryland 1 4 1 Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 3506 South Forest Edge Road 20747 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or. 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify: Specify: White "natural", 3 Wldowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) National Institute of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maggie Grav Rosier **Embery** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Marie Hardy (Daughter) P.O. Box 123 Faulkner, MD 20632 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Sept 29, 2010 Brentwood, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ Medical resulting in death) **Examiner** Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Dav Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 124b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Pyactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Gladys Heatley, M.D. 6001 Landover Road, Cheverly, MD 20785

Physician/	
Medical	
Examiner	

1 - For State Registrar

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036 Physician/ Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death 3. Date of Death 4. Date of Death 5. Date of Death 6. Date of Death 7. Date of Death 8. Date of Death 9. Date of Death 9. Date of Death 9. Date of Death 1. Decedent's Name (First, Middle, Last)										OTO	3. Time of D 4:00 P			
Medic Examin		4a. Facility Name (if not institution,	4b. City, Town, or Location of Death 4c. County of Death											
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Funeral Director		5. Social Security Number 578-84-5574		(In yrs. Ia 51	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birti	195°			ace (State or F arolina	
		Usual Residence of Decedent		10- 0"	. Taura a d	nation .								
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or 282 notif		10e. Street and Number	ocorge 5	11,	, wasii	10f. Zip Code				10g. Cit	tizen of Wh	hat Count		AA FE
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r item: ner m		11. Marital Status	12. Was Decedent Ex Armed Forces?		5. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Orig ın, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race Black,	- America , White, et		
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iis cert directi	10 B(examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatier	Oth	er.		one 5 to Residence 6 □ Other (Specify)					
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winnit 44 nous and each cearl. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	Medical	(Check P Medical E	Physician: To the best of rixaminer: On the basis	mination	n aut/or inv		on, death oc	curred at t	he time, date a	ind place	e, and due t	to the caus	se(s) and mani	ner stated.
To th		29b. Signature and title of certifier	1 11111	ill	ut	29c. Licenso	number	20		29d. Da	ite styrned	(Month, D	ay, Year)	
1		30. Name and address of person of Dennis A. Pri		ath (Item O Ir	ving S	rint) treet N.V	V. Was	hing	ton, D	.C.	200	010		
Sta Registr		31. Date filed (Month, Day, Year) SEP 2 9 2010	32. Registra	r's Signat	and									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** September 21, 2010

4c. County of Death Shirley Ann McNamara /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctor's Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days **Funeral** Hours Months 1 □ M 2 🕱 F Vernon, OH 218-30-3584 79 June 25, 1931 Mt. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show Examiner must be notified at 1 □Yes 2 No Directo Maryland Calvert Lusby 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 USA 385 Canyon Court items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other tha any Injury or other traumatic event, the 1 once. 12 Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Schaelar Fred Crago 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joyce A. Harber / Daughter 385 Canyon Court, Lusby, MD 20657 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 9/29/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Leave 7 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 061 **Physician** /Medical Due to (or as a consequence of): Examiner 26H 57 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed 1ABETES use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ be 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Tes 2 ☐ No 24a. Was an autopsy performed 12 Yes 2 page 2 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 1 within 24 hours after deat To the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEOK

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State of Marylan Registrar	•	tificate of E			eg. No.	32095		
Physic	cian	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Year	3. Time of Death		
/Med	lical	Wade Arlan McCoy 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Septemb	er 25, 201			
Exam	iner	820 Sollers Wharf Road		Lusby			Calvert			
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/13/1	Year) Co	thplace (State or Foreign ountry) York		
and		Usual Residence of Decedent 10a, State 10b, County 10c, Ci	ty, Town or Loc	cation				10d. Inside City Limits		
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ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinet must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ∰ Married 1 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ∰ Yes, 2 □ No If Yes, Give Year or Dates: 1955-		Nas Decedent of Hi fYes, specify Cuba 1 □ Yes 2 ⋈ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ame Black, Whit			
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Malynd 2 sho alth and 1 27 is maler traume		Joanne Mary McCoy / Wife				or Rural Route Number, City or Town, State, Zip Code) y, Maryland 20657				
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	ouce.	21. Signature of Funeral Service Licensee		2. Name and Addres P.O. Box 600			al Home, P.A. 1657			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consect of the condition of the consect of the condition of								
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VILAI sician: T certifical rector, pa	a	25. Was case referred to medical examiner? Hospital: Hospital:	7-240 1 11	nt 3 🗆 DOA Othe	26. Place of Deater:					
Attending Physic death. ector: After this by the funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time o	f 28c. Injur	y at		ence 6 ☐ Other (Sp ow injury occurred	ecify)		
DIVISION Attents after deaf	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 188e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					itreet and Number or F n, State)	Rural Route Number,		
e Hospit 124 hour e Funera letely fille	Medical (29a. Certifier (Check only one) 1								
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)		
1		hatelfiled		000	59061	-	septenber	at 2010		
Mr.		30. Name and address of person who completed cause of death (Ite A2A71 PA761 IIO IDSP		Road,	Suite 2	12 Pr	rince Fre	27 h 2010 MB 20676 denck		
1000	State	31. Date filed (Month, Day, Year) 32. Registrar's Sign			-					
Reais	strar	SEP 2.7 2010 6	1							

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State

Registrar

(anyeal

SEP 28 2010

31. Date filed (Month, Day, Year)

4409

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32. Registrar's Signature

10-07324

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mattnew Moenia	au	State of Maryla 1- For State Registrar	nd / Department o <i>Certificate o</i>	if Health and Mental F f Death	lygiene Reg. No	.2010	32007		
Physician Medical Examine		Decedent's Name (First, Middle,Last) Matthew	Machlau		2. Date of Death Month Day September 23	L U 1 U	3. Time of Death 1435 hrs		
		Facility Name (if not institution, give street and nur Suburban Hospital		4b. City, Town, or Location of Deat Bethesda	h 4	4c. County of Death Montgomery			
Funeral			7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth(MN	M/DD/YYYY) 9. Birth			
Director		218-04-3247 1X M 2 F Usual Residence of Decedent	32 yr	Months Days Hours Mir	01/01/	1978 Foreign Cour	intry)Virginia		
w any		10a. State 10b. County	10c. City, Town or Loca				10d. Inside City Limits		
Maryland 28a-f show <u>d at once.</u>	Director	Maryland Montgomery 10e. Street and Number		Silver Sp.	ring	itizen of What Count	1 X Yes 2 No		
th the M 23a or 2 notified		308 Pinewood Aven		20901		и	S.A.		
death with the ritems 23a	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Dece		as Decedent of Hispanic Origin? (S res, specify Cuban, Mexican, Puerto		14. Race - America White, etc.	an Indian, Black,		
rs after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade)	1	Yes 2 X No specify: nt's Usual Occupation (Give kind of	undi dana Ideh	Specify:	White		
6 n 72 hou an "nat ical Exa	leted	Elementary/Secondary (0-12) College (1-	4 or 5+) during m	nost of working life. DO NOT use ret	ired)	. Kind of Business/Ind	,		
5-003 ed within tygiene. other th	Completed by	12 17. Father's Name (First, Middle, Last)	Tow T	ruck Company Man. 18.Mother's Name	ager e (First, Middle, Maider	Transport Surname)	rtation		
21215 Ild be fill Mental H narked event, t	To Be	Drew Moehl 19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or		Mingin	7-0-1		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Deidre M. Turner - Moth	er 9 Nor	mas Lane. Richmo	nd. Virgin	ia 23238	12		
IOFe, ges 1 an nt of Hea t: If iter other tr		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal fro	m State 20b. Place of Dispos crematory or ot	sition (Name of cemetery, her place)	Date 20c.	. Location - City or To			
altim mit. Pa spartmer sportant jury or	1	4 Donation 5 Other Spedify: 21. Signature of Funeral Service Liberts e		Ln Crematory 09/					
ம் உத்தத் Physician	- 1	23a. Part I. Enter the disease, or complications that ca	01291 1118	800 New Hampshure	2 Ave. Sil	lver Sprin	ng, MD20904 Approximate Interval		
/ Line	ı	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive		Between Onset and Death					
2		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
_ 6	Examiner	if any, leading to immediate course. Enter Underlying Cause (Disease or injury that initiated							
cut md md transit		events resulting in death) Last Due to (or as a d	consequence of):						
60, tte be execut nysician and e burial - transit	ledical	UNPENDED AMENDED IF FEMALE: 23c, If yes, or							
Box 68760, e death certificate be the attending physicied for use as the buri	21	past 12 months?	at at time of death	tal death 3 Ectopic pregna		3d. Date of delivery Month Day	y Year		
BOX ne death the atte	Physic	1 Yes 2 No 9 Unknown 9 Unknow	/n	her (Specify)					
Division of Vital Records, P.O. Box 6876 is or Attending Physician: The law requires that the death certifica is after death. al Director: After this certificate has been signed by the attending phed in by the funeral director, page 2 should be detached for use as the	Ď	Part II. Other significant conditions contributing to a	death but not resulting in the u	inderlying cause given in Part I.		use contribute to the			
ords aw requi	Completed				24a. Was an autopsy	prior to con	psy findings available mpletion of cause of		
Rec n: The l tificate h		25. Was case referred to medical		26.Place of Death (Check)	performed? 1 Yes 2 N	death? 1 Yes	2 No		
F Vita Physicial r this cer	e P	examiner? 1 ✓ Yes 2 No Hospital: 1 In	patient 2 🗹 ER/Outpatient	3 DOA Other Nursin	g Home 5 Reside				
Sion of Attending I death. xtor: Afte vy the funer		27. Manner of Death 1 V Natural 5 Pending 28a. Date of (Month, E	f Injury 28b. Time of Ir Day, Year)	njury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	ury occurred			
Divisi al or Att s after de 1 Direct	Certification:	determined (Secretary	of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Street a or Town, State)	and Number or Rural	Route Number, City		
ia a a a iii O 29a Certifier						nd manner as stated			
To the Hos within 24 h	Medical	2 Medical Examiner: On the basis of and manner sta	examination and/or investigati		t the time, date and pla		cause(s)		
12	-/	Salalemos		O.C.M.E.		otember 24, 201			
		30. Name and address of person who completed cause Laron Locke MD. Assistant Medical	,	Street, Baltimore, MD 212	 D1				
		31. Date filed (Mönth, Day, Year) 32. Regi	strar's Signature	7					
Regist	Cli_	SEP 28 2010 Annua	7 7. 17						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1738 N Robert W. Mathis, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO TENINGULA REGIONAL Medical Center SAL1364 R4 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
May 12, 1963 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** Months Country)
Texas 1 🔀 M 2 🗆 F Yrs. **Director** 456-84-9608 47 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 X No MD Wicomico Delmar ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 104 Woodlawn Avenue 21875 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21x No Specify: white Specify: 3 ☐ Widowed 4 XX Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic month. Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Manager Food Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ R. Wayne Mathis Doris Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Woodlawn Avenue R. Wayne Mathis (Father) Delmar, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 09-26-1010 Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 East Grove Street Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Asuro ₽πysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Other (specify) Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? has autopsy performe certificate 1 Yes 2 No Yes 2 **Division of Vital** 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital No No Other: 1 Tes ္ဝ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? after death.

Director: After to in by the funera 28d. Describe how injury occurred 1 Natural injury 5 Pendina 2 🗌 No M 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) completed filled in 24 hours a Funeral L Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/10. D63199

State Registrar 30. Name and a

31. Date filed (Month, Day, Year)

SALISBURY Md 2180

press of person who completed cause of death (Item 23a) (Type, Print)

VOHRA MD

2010

8

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Ellsworth Martin September 2010 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, 1 XM 2 □ F Months Days Hours Year) Country 90 Yrs 218-12-8822 **Director** 1920 Maryland Sept. Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Carroll Hampstead 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4206 South Hunter Road 21074 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1944.
If Yes, Give 1946 Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. white 1946 Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manufacturing mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ B. Edwin Martin Nettie V. McComas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean E. Martin - son 4206 S. Hunter Road Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Carroll Cremation 9/24/2010 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio-22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ey h line. Approximate Interval Between Onset and Doth Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a content ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sloned by the attendion abusinan and been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**℃** No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Pother (Specify) to sate 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Novatural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

8+IVA

DHMH 17 Rev 7/2009

Registrar

4231 Northwoods Trail

Hampstead, Md. 21074

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

D. Alexander Rocha, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:45 PM Hazel Moxley Sept Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Senior Constant Care Svkesville Carroll Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months 1 M 2 X F Hours Min 1072471917 Country) Director 220-09-8301 92 MD Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2XXNo Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 747 Central Ave. 21784 USA items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Hygiene. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Nursing Aide Springfield Hospital marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hayes Gue Virginia Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna Burdick/Granddaughter 19511 Marsh Circle, Hagerstown, MD 21742 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Marvin Chapel Cemetery 9/24/10 Mt. Airy, MD Funeral Service Liga 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. W. Old Liberty Rd., Winfield, MD 21784 Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of each line. Immedia Cause (Final 4 Physician/ or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and -transit Due to (or as a consequence of) resulting in death) Last burial Physician/Medical that the death certificate be Box 68760 phys the k IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 🗆 No] Yes 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury s after death. I Director: After doin by the fu 2 Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number MIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELDERSBURG

Registrar DHMH 17 Rev 7/2009

State

MCEVO

31. Date filed (Month, Day, Year)

PROGRESS

380

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -16, Physician/ Dorothy Virginia Merrick 2010 September 9:16 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, Year Days Hours Min. 1 □ M 2 🔀 F 939 Maryland 216-36-3992 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director Cockeysville Baltimore Maryland 1. Yes 2 X No 50 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 206 Duke of Kent Court, Apt. 103 21030 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) or other traumatic event, the Dept. of Education 12 School Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Hupfl Erma (maiden name unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 206 Duke of Kent Ct., Apt. 103 William Edward Merrick III / husb. Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 18, Hampstead, Maryland injury Carroll Cremation 2010 21. Signature of Funeral Service Lice See 22. Name and Address of Facility Eline Funeral Home any M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Carrer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? importeent Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number comp 09-16-201 K125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lewis N. charles 4

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2010

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 9720/2018 EVANGELINE E. MINES 6:23 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HCR MANOR CARE HOME CHEVY CHASE MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days MAY 6, Day, 1 952 1 . M 2 . 577-68-4503 58 WASHINGTON, DC Director Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No VA HANOVER **ASHLAND** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 SLASH COURT 23005 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) BON SECOURS Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL ASSISTANT HEALTH SYSTEMS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည JAMES KING ANNIE LEE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3707 ANYOR DR. MITCHELLVILLE, MD 20721 LINDA CROCKETT / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ROSELAWN MEMORY GARDENS 9/27/2010 GLEN ALLEN, Signature of Funeral Service Licensee 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 3005 12th ST. NE WASHINGTON, DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRO Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) signed by the attending physician and defacthed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 3 5 Other (specify) Month Pregnant at time of death Day Year Yes 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗗 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After that in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide
Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier wo i was DO057124

State Registrar

32. Regis ar's Signature

#201 ROCKVILLE, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRUONG BAO 9715 MEDICAL CENTER DR. #20

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ MCILWAIN MAE 4:08 A M EVA SEPTEMBER 22 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Hours (Month, Day, NOV . 2 Days Min. 1 □ M 2 🕱 F SOUTH 1924 CAROLINA Director 230-46-1126 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 ☐ No PRINCE GEORGE'S GLENARDEN MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral with 1 20706 USA 1414 WESLEY STREET 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. þ 1 X Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🛣 No BLACK Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation. 15. Decedent's Education 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M PRIVATE MILL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ CALVIN MCILWAIN FREDONIA WADE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1414 WESLEY STREET GLENARDEN, MARYLAND 20706 ELIZABETH CAUTHEN/SISTER Baltimore, 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 9/30/2010 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician at the burial-t Medical Box 68760 attending p as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Physician/ 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Yea Day Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy 1 Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛭 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature nd tit of certifie . Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT. 2010 EARLINE В. NOYES 2:56 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY **BETHESDA** 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Hours Min. (Month, Day, Country) LOUISIANA Director 067-28-6440 4, 1915 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MONTGOMERY 1 XYes 2 No MD. SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8505 SPRINGVALE RD. 20910 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 x Widowed 4 ☐ Divorced Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES BOISLEY LUBERTHA TALBOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra YVETTE WILLIAMS/DAUGHTER 10903 HENLOPEN CT., SILVER SPRING, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 9-27-2010 RIVERDALE, MD. 21. Signature of Funeral Service Lipersee CHAMBERS FUNERAL HOME & CREMATORIUM, M00091 5801 CLEVELAND AVE., RIVERDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset of Death ALDOVASCULAR Physician disease or condition resulting in death) MERIO Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HUPORTENSIAN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an O age perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Other: 1 Tes 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural injury **2**E 5 Pending Certifical Accident Investigation 6 Could not be the Funeral Directo Suicide 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0 (Check within 2 only one) License number 29d. Date signed (Month, Day, Year) 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD GEALLET CHN 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 7:00 AM 24, 2010 Sept. Elkanah Preston Parks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 31840 Wildwood Drive Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 216-38-7643 June 25, 1940 70 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 No Director Maryland | Somerset Princess Anne 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number 31840 Wildwood Drive 21853 IIS Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ 12 Maintenance Worker Gas Pumps 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Wilson 2 Edward Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary E. Parks Wife 31840 Wildwood Drive, Princess Anne, Md. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) St. Peters Cemetery 09/29/10 Oriole, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hinman Funeral Home MO0295 11673 Somerset Ave, Princess Anne, Md. 21853 23a, 371. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imp diate Cause (Final 8 MINTHS melastatic squamon cell diff ase or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to lor as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → Ho 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available

Physician /Medical Examiner

and

attending physician

signed by the

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After

s after death

To the Hospital within 24 hours a To the Funeral I the Hospital

filled in by

or Attending Physician:

item 27 other to

injury or Department of Important; If any injury or once.

Pages 1

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

burial-trai the pe page 2 director. funeral the

Be

Certification: To

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

death?	oompromorr or	04000 0.
1 ☐ Yes	s 2□No	

25. Was case referred to medical examiner? 1 | Yes 2 No 27. Manner of Death 1 Natural 5 Pending

investigation

6 Could not be determined

1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? Injury 1 □ Yes 2 □ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Lettiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Torrer

29c. License number

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. DIVISION ST. SALISBURY RODWEY 1346 WENRICH 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) \(\cap \) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOYCE MARIE PROCTOR rentembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Medica La Plata harles Civista Cente Social Security Number 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 👿 F Months Min JULY 18 1946 213-44-5471 64 Director MARYEAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified 28a-f CHARLES MARBURY 1 X Yes 2 ☐ No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 4150 SWEETMAN ROAD 20658 UNITED STATES items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2X Married ō 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Wildowed 4 Divorced any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha 6TH GRADE HOMEMAKER HOMEMAKING Be Baltimóre, Máryland be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 PHILIP STERLING PROCTOR MAE EDITH THOMPSON PROCTOR permit. Page 1 and 2 should in Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4150 SWEETMAN ROAD, MARBURY, MARYLAND BRENDA MADDOX / DAUGHTER 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ST. JOSEPH'S CHURCH CEM. OCT. 2, 2010 4 Donation 5 Other (Specify) POMFRET, MARYLAND nature of Funeral Service Lice 22. Name and Address of Eacility HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc / as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the birrial. Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent preg 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Dav 9 Unknown signed by t ant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? [조 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 sh 24a. Was an autopsy 2 No Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examine Hospital: ျ 2 Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) r of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work in 24 hours arter control the Funeral Director. A 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) etermined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or in Certifying Nurse Practioner: To the best of my knowled (Check estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only or ge, death occurred at the time, date and place, and due to the cause(s) and man 29b. Signatu 29c Licen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Morth, Day, 32. Registrar's Signature

Registrar

Physician Medical **Examiner** For State Registrar

10a. State

. Signar

21

Physician/

Funeral

Director

28a-f show

ıral", or items 23a or 28a-f sho Examiner must be notified at

the Medical

I Hygiene.

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permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once.

with the Maryland

hours after death

Baltimore, Maryland 21215-0036

Medical Examiner

Director

Funeral

by

Completed

Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burnal-transit

Division of Vital Records, P.O. Box 68760

23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused the dea one cause on each line.	')		ac or respiratory arrest,	Approximate Interval Between Onset and Death	
disease or condition resulting in death)	a/_	Kespi	ration	TA1010		
	b. Due to (or as a consect	quence of): ACul	e Rene	e Patu	re	
cause. Enter Underlying	Due to (or as a consen	duelice of	11.1. (N. C.	en a	
that initiated events	C	Metz	Wtahc	MOJ NOTE	Lnome	
resulting in death) Last	Due to (or as a consec	quence of):				
	l d		· · · · · · · · · · · · · · · · · · ·			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inition) that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌 Ectop	ic pregnancy (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
25. Was case referred to medical			26. Place of Death (Ch			
examiner? 1 Yes 2 No	Hospital:		Other:			
27. Manner Death		ER/Outpatient 3	DOA 4 Nursing	Home 5 Residence	6 Other (Specify)	
1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inju	ury occurred	
4 Homicide determined	e 28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact fy)	28f. Location (Street a City or Town, Star	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
(Check 2 L Medical Exami	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of m	on and/or investigation.	in my opinion, death occurred	at the time, date and place	ce, and due to the cause(s) and manner state	
27. Manner o Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not b determined 29a. Certifier 1 Certifying Phys (Check 2 Medical Examionly one) 3 Certifier Questions (Certifying Nurs)			9c. License number		late signed (Month, Day, Year)	
D CA	+ IND		MDD 60611		G1061261P	

Good Luck Rd Lonham, M.D. 20706

State Registrar

8118

ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Katharine S. Prince 11:25 PM September 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collington Episcopal Nursing Home Prince George's Mitchellville 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, April 1 If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Davs Hours 007-28-8943 **Director** New York 930 Usual Residence of Decedent 10a, State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Prince George's Mitchellville 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? with 1 Funeral 10450 Lottsford Road 20721 USA items ? filed within 72 hours after death "natural", or iten edical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗵 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ital Hygiene. ed other thar event, the N Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ge 1 and 2 should be find of Health and Mental ပ Sylvester N. Stevens Katharine B. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Prince / Husband 10450 Lottsford Road, Cottage 2109, Mitchellville, MD 20721 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Department o Important: If any injury or once. ò 9/28/2010 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Arterioscleroti Cardiovascular disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Fibrillation Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) transit. and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending pł d for use as ti IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day 2 X No the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an 24b. Were autopsy findings available Jas autopsy prior to completion of cause of page perform death? certificate 1 ☐ Yes 2 🔀 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🔀 No 1 Yes Other: ည After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 🖺 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending death. 1 Yes 2 No neral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined hin 24 hours a the Funeral D npleted filled i Hospital Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CF 5 State

Cielito Miguel Aguinaldo, 1221 Mercantile Lane, Largo, MD 20774

Date filed (Month, Day, Year)

SEP 2 9 2010

32. Registar's Signiture

SEP 2 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar

U41945

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18&I9a Per FH G908 10/14/10 Jh State of Maryland / Department of Health and Mental Hygiene Amended ited - State #26, per physician, 9/23/10 ertificate of Death E.T., WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Anna Piteo 7:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1510 Baltimore Ave. Ocean City Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Min. Director 63 102-38-7051 Italy Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits NV Rockland 1 Yes 2 No New City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 165 Old Rt 304 10956 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or it Armed Forces Black, White, etc. 1 Never Married 2 Married hours after Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes Give 1 Tes 2 No Specify. 3 Widowed 4 Divorced Specify: Year or Dates white 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working life. ĐO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Homemaker is marked other Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrizzo Francesco Fidanza Maria Antonia 19a Informant's Name/Relationship (Type, Print) **GLOVANNÍ** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 10Vanni Piteo / husband 165 Old Rt 304, New City, NY 10956 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Anthonys Cem. 9/18/2010 Nanuet, NY 21. Signatur of June al Sen 22. Name and Address of Facility Burbage Funeral Home 108 William St Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ etustatic Malignant carcinoid tumor disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month ☐ Pregnant at time of death☐ Unknown 5 Other (specify) Day Year cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home -5 Residence 6 Other (Specify) Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 10014314 13 20 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 & Court eput, Soli buy, mr. 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#9. PerFHPGC10-6-10cr Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September23,2010 Physician/ Randy L. Perrin 5:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) Georgia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Min. Hours 1 🔀 M 2 🗆 F 56 Director ulv20. <u>578-72-7984</u> Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 XYes 2 □ No MDPrince George Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6108 Omar 20772 Court USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Defense Administrative Technician <u>12±h</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johnny Columbus Juanita Perrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Perrin (Wife) 6108 Omar Court Upper Marlboro Md.20772 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Clinton Maryland Oct2,2010 Resurrection Cem 4 Donation 5 Other (Specify) 20011 of Funeral S Licensee 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St. NW WashDO er the disease, or complications that capeart failure. List only of cause on pa Approximate Interval Between Onset and Death heart failure. List only Immediate Cause (Final Ta Physician/ a disease or condition Medical resulting in death) Due to for as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at the detached for 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of 24 hours after death.
Funeral Director: After this certificate has autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 XNo 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 🗆 within 2 To the F only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) luga

CR 10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			l-For State Registrar	Cer	tificate of	Death		Re	g. No.	0 0 2 7		
Phy jedical Ex	ysicia xami	an/	1. Decedent's Name (First, Middle, La Mark Stuart Pla			b. City, Town, or Lc		2. Date of Deatl Month Septembe	Day Year 26, 2010	3. Time of Death 1907 hrs		
-			4a. Facility Name (if not institution, g 1931 Watson Road	ve street and number)		4c. County of Death Calvert						
Fun Dire			5. Social Security Number 6. 9 15 15 16 15 16 16 16 16 16 16 16 16 16 16 16 16 16	7. Age (In yrs. la	-	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State 11/11/1959 FL						
	м апу	_ h	Usual Residence of Decedent 10a. State 10b. County		Town or Location	on				10d. Inside City Limits 1 Yes 2 X No		
Maryland	23a or 28a-f show notified at once.	Director	MD Calver		WINGS -	10f. Zip Code 207	 36	10	g. Citizen of What			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene.	tems 23a oi st be notifi	era	1931 Watson Road 11. Marital Status 1 Never Married 2 W Married	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ar White, etc.								
rs after dez	ural", or i miner mu	by Fun		1 Yes 2 X No		Specify: White						
36 thin 72 hou e.	other than "nat the Medical Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	vork done red)	NCIS						
215-0036 be filed within 7 ntal Hygiene.	ked other ent, the M	Be Con	17. Father's Name (First, Middle, Las Peter Plastow	tt)	faiden Surname)	iden Surname)						
MD 21 d 2 should l th and Mer	umatic ev	٩	19a. Informant's Name/Relationship Bonnie Plastow	/Wife	61 A1	mory Roa	d, Princ	ce Frede	ber, City or Town, Serick, MD	20678		
Baltimore, I permit. Pages I and Department of Healt	Important: If item 27 is marked oth injury or other traumatic event, the		20a Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specie	Removal from State	Place of Disposerematory or other Cremat			Date 01/2010	20c. Location - Ci Clinton			
Balti permit. Departm	Imports injury o	4	21. Signature Tuneral Service Lice Lisa M. Mounts	ensee	[812	25 Southe	rn Ma B.	rva., Ov	vings, Mu			
Physic Med		1					uch as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death		
		-e	or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence or Due to (or according or Due to (or accordin								
	_	Examine	if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o								
760, icate be executed	physician and he burial - transit	/Medical E	UNPENDED	d								
	the attending physical	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fe	tal death 3 ner (Specify)	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year		
- 2	signed by the at the detached for	by Physician	1 Yes 2 No 9 Unknow	a Oukuowu	esulting in the u	nderlying cause giv	ven in Part I.			te to the cause of death?		
of Vital Records, P.O.	should be	Completed t						24a. Was	an 24b. We	re autopsy findings available or to completion of cause of		
II Reco	certificate ha	e Com	25. Was case referred to medical	Г		26.Place	of Death (Check	1 Yes	med? dea 2 ✓ No 1	ath? Yes 2 No		
Vita	dir.	ě	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursir	ng Home 5	Residence 6	Other: Scene		
on of tending Ph	After		27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investig:		28b. Time of t		at Work?	28d. Describe	now injury occurred			
Division pital or Attendion ours after death.	filled in by	Certification	3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At h	ome, farm, stree	et, factory, office bu	illding, etc.	28f. Location (or Town, S		or Rural Route Number, City		
To the Hosp	To the Funeral Director: completely filled in by the	Medical C	one) 2 Medical Examir	ician: To the best of my knowled er:On the basis of examination a and manner stated.		tion, in my opinion,	death occurred a		and place, and due	to the cause(s)		
	F 0	M	29b. Signature and title of certifier			29c. License			29d. Date signed September 2	(Month, Day, Year) 27, 2010		
Jaw 1	0			o completed cause of death (Item stant Medical Examiner		Street, Baltim	ore, MD 212	201				
R	Si Regis	tate trar	31. Date filed (Month SEP 29	2010 Seneral's Signati		ake						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **24** 3. Time of Death Month Physician/ 12:20pm Phep Thi Phan September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🕱 F 1273777974 Hours Min. Director Vietnam 220-35-5981 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director Rockville 1 X Yes 2 No Maryland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 6121 Montrose Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Š 1 Never Married 2 Married ☐ Yes 2 🗓 No 1 Yes 2 X No Specify. If Yes, Give Specify Completed 3 X Widowed 4 Divorced Asian Year or Dates er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Mau Nauuen Tien Van Phan e 1 and 2 should b of Health and Mer fitem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12573 Scenic Ridge Trail, Fairfax, Virginia 22033 Chau Minh Le - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1 🗓 Burial 2 🗌 Cremation 3 🗌 Removal from State Parklawn Memorial Pk. 09/28/2010 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO189 MD20904 1800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Sepsis daus Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Renal Failure 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Supraventricular Tachycardia autopsy performed? Yes 2 X No Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate b Myocardial Infarction 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No မ 1 A Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Hitle of certifier 29d. Date signed (Month, Day, Year) 29b. Signa D60117 September 24, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 8600 Old Georgetown Road, Bethesda, Maryland 20814 Eric Joon-Shik Park.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP 28 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Joseph Puglisi 2320 M September 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Months Hours (Month, Day, Year) 01/24/1933 washington. **Director** 578-42-4872 77 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location Director 1 Tes 2 X No Maryland Clarksville Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13785 Brighton Dam Road 21029 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Salesman Computer Be it. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles J. Puglisi Maria Venuto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13785 Brighton Dam Road, Clarksville, Maryland 21029 Patricia Puglisi - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Dogation 5 Other (Specify) George Washington Cem 09/30/2010 Adelphi, Maryland 21. Sign ture of Funeral Pervice bi 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, br heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Non-Alcoholic Cryptogenic Cirrhosis 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the 74 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-tunist Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 🗆 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autops, performed: 2 X No prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No <u>유</u> 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, uean occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tle of certifie 29b. Signature and t 29d. Date signed (Month. Day, Year) D44427 September 27, 2010

Registrar

State

7120 Minstrel Way, #100, Columbia,

Maryland 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28 2010

Rudrajit Rai.

31. Date filed (Montin, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death September 26, 2010 Physician/ 11:35AM JOHN L. PALMER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER BERLIN NURSING & REHAB. BERLIN CENTER 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Hours Min Months 1 🕅 M 2 🗆 F MARYLAND Yrs UNE ĩ 926 **Director** 220-26-3765 84 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County within 72 hours after death with the Maryland Director X Yes 2 □ No BERLIN MARYLAND WORCESTER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 102 CHERYL AVE. 21811 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Å Ves 2 □ No If Yes, Give Year or Dates 944-46 14. Race - American Indian. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 XMarried Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meginee. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AUTO DEALERSHIP AUTO PARTS MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Palmer, John မ BERTHA DAVIS CALVIN н. PALMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERLIN, MARYLAND 21811 102 CHERYL AVE., BETTY J. PALMER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/29/10 BERLIN, MARYLAND 4 Donation 5 Other (Specify) VERGREEN CEMETERY Egheral Service Licenses 22. Name and Address of Facility Signatu HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any leading to immediate Examiner Due to for as a consquence of cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital 1 Tes Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 1 X Natural 5 Pending injury work?
1 \sum Yes 2 \sum No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R 135131 September 27,

DHMH 17 Rev 7/2009

State Registrar 9715 Healthway Dr., Berlin,

MD

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32, Registrar's Signatur

Pennie Savage,

2 8

31. Date filed (Month, Day,

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:55 24, 2010 Augusta J. Propper September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5400 Vantage Point Road Rm 413 Howard Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X Yrs. 132-09-3115 Director 90 June 11, 1920 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number p e 5400 Vantage Point Road 21044 United States "natural", or items 23a Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No <u>م</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F

27 is marked otl Charles Stanley Jacobs Pauline Breslauer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 10144 Spring Pools Lane Columbia, Maryland 21044 Suzanne P. Silber/daughter Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' permit. Pages Department of I Important: If Ite any Injury or o ō 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 9/28/2010 Woodbine, Maryland 21. Signal of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Homas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Parti, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duw to far as a consequence of Examine burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 0 Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 2 SIND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 633 6 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **SEP 28** parks Registrar

DHMH 17 Rev 1/2001

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Division

ours after death. Hospitai 24 hours completely To the within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 45471 9/19/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD 20910 M.D. Yeheyis Negussie, 31. Date filed (Month, Day, Year)

State Registrar 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended #19a per FH, RG, FCHD 18 of the of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September 23, 2010 6:00 AM Franklin Grover Rappold /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Homewood At Crumland Farms Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1XM 2□ F Yrs. March 1, 1914 96 Maryland 212-05-2275 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X☐ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 United States 7401 Willow Drive, Unit #272 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married White 1 ☐ Yes 2 ☒ No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Antique Dealer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Spickerman Howard F. Rappold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 7401 Willow Road., Unit 272, Frederick, MD 21702 Eleanor Rappold / DaughterWife Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 9/28/2010 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Rome 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause op each line. and Death year) Immediate Cause (Final rtinson's Didoug **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No 1 Yes Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: A
filled in by the for 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58 390C 23/10 PUTTE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Austin Pearre MD, 300 West 9th Street, Frederick, MD 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 4 20 0 State Darke Cenera Registrar

rankli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 20, 2010 Physician/ RICHARDS MAGDALENE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTORS COMMUNNITY LANHAM HOSPITAL 8. Date of Birth (Month, Day, Y August 2, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 6. Sex Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🔀 F Hours 1934 Philadelphia, PA Director 577-46-6443 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1x Yes 2 No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō rral", or items 23a o Examiner must be Funeral UNITED STATES 20003 STREET S.E., Washington, Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Hygiene. Specify: Completed 3 🛮 Widowed 4 🗆 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) FORENSIC TECH. FEDERAL GOVERNMENT and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 JOSEPH TASCOE PRATT BAILEY IDA Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7543 NEWBERRY LANE, LANHAM, MARYLAND 20706 item 27 RHONDA MASON-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State LINCOLN Cemetery 9-28-2010 BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify) Ft. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 5538 MARLBORO PIKE, POPE FUNERAL HOMES, PA. FORESTVILLE, MD. 20747 may 0401085 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be P.O. Box 68760 phy use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Year Day Pregnant at time of death the i 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performed Hospital or Attending Physician: The 1 🗌 Yes 2 🗎 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Tyes 2 No after death

Director: A
d in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21 O lab Muel 606 completed cause of death (Item 23a) (Type, Print) Geod Luck ROAD 31. Date filed (Month, Day, Year) State SEP 2 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ РМ Irene Mason Schmeusser October 0 1400 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 16 Hamer Road Elkton Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours AUG 24. 1924 1 □ M 2 🗓 F Months Days Gountry) New York **Director** 86 222-14-6894 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Directo 1 ☐ Yes 2 🕅 No Delaware New Castle Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 19808 607 Dandenog Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 X Widowed 4 Divorced White Year or Dates any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during life. DO NOT use retired) (Specify only highest grade completed) most of working Real Estate marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Rental/De<u>velopment</u> Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental I ျ Frank Mason Ida Lavonen and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 shot Health and tem 27 is n Janet L. Hayes/Daughter 607 Dandenog Drive, Wilmington, DE Baltimore, tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 6 Page 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ir portant: If 4 Donation 5 Other (Specify) Silverbrook Cemetery 2010 Wilmington, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) node Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence or) and I-transit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death g Unknown Records, P.O. þ, signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy director, page 2 performe 1 🗌 Yes Yes 2 Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 000 မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No Investigation Could not be Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ For	State of	Maryland	/ Depa	rtment rtificate	of He	alth a	and Me		iene	10	22121
		1 - State Registrar 1. Decedent's Name (First, Middle,			Cer	cale	UI D			Date of Deat	h	<u> </u>	3. Time of Death 1500 M
Physic /Medi Examii	cal	HERBERT E. SEGE 4a. Facility Name (If not institution,	give street and numb			4b. City, To				LI I LI II	4c. Count	by of Death	
Funeral		ANNE ARUNDEL ME 5. Social Security Number 487-38-2285	DICAL CEN Sex MM 2 F	IEK . Age (In yrs. las 77	t birthday) Yrs.	If Under 1		If Under Hours	24 Hrs. 8. Min. J	Date of Birth (Month, Day AN. 4,		9. Birth	place (State or Foreign
or 28a-4 show		Usual Residence of Decedent 10a. State 10b. County	ARUNDEL	10c. City,	Town or Lo								10d. Inside City Limits XXYes 2 □ No
with the a or 28a	Director	10e. Street and Number 1271 LAVALL DR				10f. Zip (1	USA	f what Col	untry ?
Ore, IMaryland ZIZI3-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item Z7 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the resilical Evanities must be southed.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tayles 2	lent Ever in U.S. ces? 2 \(\) No etes: \(\) 57 \(\) 80	i	Was Decede If Yes, speci		panic Or , Mexical Specify.		ify Yes or No- can, etc.)	14. R B	lack, White	rican Indian, e, etc. I TE
within 72 hours afi within 72 hours afi iene. than "natural", or the Medical Exami	Completed b	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education	4or 5+)	16a. Dece (Give life.	dent's Usua kind of work DO NOT us NEER	l Occupa k done di e retired)	tion uring mos	st of working	7	16b. Kind of		Industry
be filed within tal Hygiene. Set other than event, the Ms	Be	17. Father's Name (First, Middle, I	Last)	5+	Littor					First, Middle,		ame)	
Maryland d 2 should be fill th and Mental H traumarked off traumaric even	2	OTTO SEGELHORS 19a. Informant's Name/Relationsl JOHN SEGELHORST	nip (Type. Print)		19b. Maili	ing Address	(Street a	nd Numb	er or Rural	Route Numbe	er, City or Tov	vn, State, 2	Zip Code)
Baltimore, IV permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S)	3 ☐ Removal from S	20b. Pla	ace of Disp	osition (Name omatory or o	of place	AN	Da	2010	20c. Location	n - City or	Town, State
Baltim permit. Pag Departmen Important: any injury	i i	21. Signature of Funeral Service	Licensee		2	22. Name an	d Addres	s of Facil	S ROA	D BOWI	E, MD	FUNER 20715	Approximate
Physiciate Physician and Physi			a. Due to (or as a consequ	ence of):	itel the mod	e or dym	9, 000.1					Interval Between Onset and Death
Box 68 eath certificat attending phy for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live !	come of pregna birth 2 Feta nant at time of d nown	death 3	B		у				Date of de	Day Year
1S, P.O. ires that the d signed by the i be detached	2	Part II. Guier dig.	ons contributing to de	eath but not resi	ulting in the	underlying	cause giv	en in Par	rt 1.		tobacco use Yes 2□N		to the cause of death? Probably 4 Unknown
Division of Vital Records, at or Attending Physician: The law requires trader death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Completed									perl 1 □Yes	opsy formed? 2 No	prior to death	autopsy findings available o completion of cause of ? es 2 \(\square\) No
of Vital Physician: 'r this certifica	a	25. Was case referred to medical examiner?		Inpatient 2	ER/Outpat	tient 3 🗆 🗈	OA Oth			n <i>(Check only</i> me 5 ☐ Rea		Other (S)	pecify)
vision of Vital Reattending Physician: The Indeath. ector: After this certificate the by the funeral director, page	T. GO!	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date (Mornitigation	of Injury oth, Day, Year)	28b. Time Injur	of y M	28c. Inju Wo 1 [_		28d. Describe	how injury o	ccurred	
Division and a stern of a stern death as Director: ed in by the	. doiteotistico	3 Suicide 6 Could determined	build	e of Injury - At h ling, etc. (Speci	(y)				a and slass	City or To	own, State)		Rural Route Number,
Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier Certify (Check only 2 Medica		e best of my kno basis of examin- oner stated.	owledge, de ation and/o	- Investigation		opinion,		red at the tim			due to the cause(s)
1		Slip	h 06	O, M			D5:	35				125	
8/40			n who completed cal	rise of death (Ite	m 23a) (Typ	Print)	M	C					
	State istra	CLU 0	7 2010	Lives _	A .	park	ノ						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Day 22 Month ^{Year} 201 09 3:30AM Donald Robert Schoeb Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7846 Radcliffe Road Chestertown Kent 5. Social Security Number 6. Sex. 1 M M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth **Funeral** Days Min. Hours (Month, Day, Year) 08/09/1934 Director 577-44-7741 76 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo KENT Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7846 Radcliffe Road USA 21620 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 | No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify:White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ 12 Foreign Service Officer Legal Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Schoeb Catheine Dwyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Schoeb - Wife 7846 Radcliffe Road Chestertown, Maryland 21620 injury or other 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) 09/27/2010 Creek Cemetery Washington, DC 21. Signature of Fureral Service Licenses any in once. 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland 23a. Pan 1. Enter the disease, or complicat shock, or heart failure. List only one ca ons that caused use on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Carcinonia unknown Weeks disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year ☐ Pregnant at time of death☐ Unknown been signed by the a should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autops, performed? Ves 2 No death? certificate ☐ Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29d, Date signed (Month, Day, Year 15

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

medicine, 6602 Church Hill Koad, Christony Manus

and address of person who completed cause of death (Item 23a) (Type, Print)

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23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death Month Physician/ PATSY MILBOURNE STERLING 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMIC TENINSULA REGIONAL Year If Under 24 Hrs If Unde 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 1 🗆 M 2 🗗 Age (In vrs. last birthday) Funeral Days Hours Min (Month, Day, Year) 1931 Maryland 79 215-26-3906 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26420 Main Street Extended 21817 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian Black, White, etc. White 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🖰 No 3 XWidowed 4 ☐ Divorced Specify. Year or Dates traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounts Secretary Paintbrush Manufacture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Helen Mister W. Wesley Riggin 19a. Informant's Name/Relationship (Type, Print) (Children) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Kim Martin & Mark Milbourhe c/o 26463 Asbury Avenue - Crisfield, MD 21817 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) Sept. 29, 2010 Delmar, Maryland 22. Name and Address of Facility SRADSHAW & SONS FUNERAL HOME Mary Beth Bradshaw-ruitt 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ò Year Month Pregnant at time of death been signed by the s 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has performed? Yes 2 No 1 Yes 2 No **Division of Vital** Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 30. Name and

Registrar DHMH 17 Rev 7/2009

State

. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

400 E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Sept 23,2010 Physician/ Barbara T. Shields 9:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington Episcopal Life Care Center Mitchellville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 578 42 4031 1 □ M 2 🗓 F 89 Mary Land Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Mitchellville 1 🗆 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Road Apt 3114 20721 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White "natural", 3 ₩ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Link Trainer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie Brookbank Norman Swann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7722 Hanover Parkway #302, Greenbelt, MD 20770 Janet Shields (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 19/27/2010 Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Juneral Service Ferry Road, Clinton, MD 20735 23a. Part 1. Inter the ashock, or heart ill.
Immediat ause (Final disease or condition resulting in death) e Iseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. Approximate Interval Between Onset and Death Arterioscherotic Vascular Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 🔀 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 30. Name appliadoress of person who completed cause of death (Item 23a) (Type, Print) GUINAL IELITO

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

32/ Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32125 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. State Registra 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 26, 2010 Year 12:05 p Physician/ Hanno Shippen Smith Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery **Examiner** Silver Spring Holy Cross Hospital g. Birthplace (State or Foreign Country) D.C. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number DeC. 1934 Months **Funeral** 1 🗗 M 2 🗆 F 75 383-32-9092 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 Yes 2 XNo Director Silver Spring Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20902 Completed by Funeral 2206 Predella Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 A Yes 2 No If Yes, Give 1955–61 filed within 72 hours after death Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: Specify: res, Give Year or Dates. 1955–61 Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) County Government and Mental Hygiene. Elementary/Seconday (0-12) Telecommunications Specialist 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Clara Russell Shippen t. Page 1 and 2 should be fill thent of Health and Mental rant. If item 27 is marked or ည James Henry Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 Predella Drive, Silver Spring, MD 20902 19a. Informant's Name/Relationship (Type, Print) Marcella Anne Smith/Wife 20c. Location - City or Town, State or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory Sept Date 27 20a, Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot Alexandria, VA 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blwd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Acute Myocardial Infarction Immediate Cause (Final Rhysician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Coronary Artery Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Congestive Heart Failure The law requires that the death certificate be executed for use as the burial-transit 120 Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23b. Was decedent pregnant Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detaction. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Kidney Disease, Atrial Fibrillation, Hypertension þ Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical To Be **Division of Vital** 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Other: 1 Nonpatient 2 ER/Outpatient 3 DOA 2 ⋤ No 1 Yes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

1041

Satyam Shah, Md 31. Date filed (Month, Day, Year)

SEP 28 2010 State

only one

29b. Signature and title of certifie

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD 20910

29c. License numbe

29d. Date signed (Month, Day, Yea September 27, 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Sept. 25. 6:15 p Corrine W. Saba M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bel Pre Health & Rehab. Center Silver Spring Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Months Hours Min. 019-20-9964 Feb. 14, 1926 84 Director Usual Residence of Decedent 3a or 28a-f show t be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Mon toomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13119 Estelle Road 20906 TISA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ₩ Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Edward Will man Sylvia Nikula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Saba Lawn/Daughter 13119 Estelle Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury or ∞t. 20io Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD . Signature of Funeral/Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 uchew 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MON ChS Immediate Cause (Final Failure to Thrive Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner vears Dementia Sequentially list conditions, if any, leading to immediate cause. Et ter orderlying Cause (Disease or linjury Due to (or as a consequence of): as the burial transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2XX No 1 Yes 2x 9 Unknown detached 9 Unknown nis certificate has been signed by a director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteoporosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 1 Natural
2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 53411 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jagdish Shesədri, MD 14300 Gallan #210, Powie, MD 20714 31. Date filed (Month, Day, Year) State Registrar SEP 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alfred Sichau 2010 Sept. 12:05AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Westminster Carroll Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F 82 Hours (Month, Day, Yea New Jersey 137-20-6446 **Director** May Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Matural", or items 23a or 28a-f shor lury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21158 USA 1246 Weller Way 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Types 2 No 1946—
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 1948 Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Chiefo Piranglal Officer/ 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Genstar Stone Elementary/Seconday (0-12) College (1-4 or 5+) Products Company Treasurer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Emil Sichau Pauline Neumann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1246 Weller Way, Westminster, MD 21158 Lois M. Sichau/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury Carroll Cremation Inc: 09/27/2010 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) disease or condition resulting in death) alzzlo-gizsino Medical Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examiner Due to for as a some squence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 2) flouring after death.

E Funeral Director, After this certificate has been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbf{N} \) Other (Specify) \(\mathbf{DUSH} \) USC ည 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 10+1 Name and address of per who completed cause of death (Item 23a) (Type, Print) State SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Alex James Smith <u>September</u> 2010 1:19A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Days Min. Hours 9/10/1922 Pennsylvania 184-18-3418 88 Director Usual Residence of Decedent 28a-f shov Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Anne Arundel Lothian 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5195 Ed Prout Road 20711 USA 12. Was Decedent Ever in U.S.
Armed Forces? WWII

1 X Yes 2 No Korea
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: 3 🙀 Widowed 4 🗆 Divorced Specify: Completed Year or Dates. Viet Nam White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Army/101st Airborne Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Smith Johanna Soltis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail M. Smith/Daughter 15205 Candy Hill Rd. Upper Marlboro, MD 20772 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation Lakemont Mem'l Gardens 9/24/2010 Davidsonville, MD. 21. Signature ç uneral Seprice License 22. Name and Address of Facility George P. Kalas Funeral Home Kalm 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gangrenous Cholecystitis Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a conse, uence of Exami requires that the death certificate be executed physician and the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law autopsy performac/? Yes 2 A No page 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 🗌 Yes ၉ 1 X Inpatient 2 □ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the form Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reynaldo Lee-Llacer II, M.D.

31. Date filed (Month, Day, Year)

D61829

2001 Medical Parkway, Annapolis, MD 21401

Sept. 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State		State of M	aryland		irtment of I tificate of I		and Me			C U 1	0	32129
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	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of									. County of D			
Ade			Holy Cross Hospital Silver Spring Montgon												
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1 $\frac{1}{1}$ $\frac{1}{$									g. (Birthpl Co <i>untr</i>	ace (State or Foreign WV	
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Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur Fund	eral Service Licen	of fun	uch	111	Name and Address					ral Ho le, MD		850
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	Medical Examiner		resulting in death)	C	Due to (or as a		,							10.0	-
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Re	sician: The law i certificate has k irector, page 2 s										perfo 1 Yes	rmed? 2 XN	death		X No
ta	sician certifi rector	m	25. Was case referred examiner? 1 ☐ Yes 2X	110	Hospital:			Oth	ace of Death		, ,				
<u></u>	ding Physician: h. After this certific funeral director,	은 e:	27. Manner of Death	140	28a. Date of injur	у 2	R/Outpatient 8b. Time of	28c. Injun	4 <u> </u>		5 Resid		Other (Sp	ecify)	
uc	nding ath. r: Afte ie fune	icat	Natural Accident	5 Pending Investigation		, Year)	injury	work	? Yes 2 □ 1			or injur	, 555454		
Division of Vital Records, P.O. Box 68	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of Inju		ne, farm, stree	et, factory, office		28f	Location (S		d Number or F	Rural F	Route Number,
Ō	oital o	- 4	20-0-15	Y 0	1										
	Hosp 24 hc Fune leted 1	Medical	(Check 2 L	_ Medical Exami	sician: To the best of oner: On the basis of exercising Practioner: To the l	camination a	and/or investi	gation, in my opinic	on, death occ	curred at the	e time, date a	nd place	, and due to th	e caus	e(s) and manner stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29b. Signature and tit		or radadiler; to the l	Joak Or Hily P	owieuge, de	29c. License		and place, 8			te signed (Mo		
	7.		Barro	ira Se	spanich.	Rem	MO	D0065	5485			09	/19/20	10	
			30. Name and addres	s of person who c	onpleted cause of de	eath (Item 2	3a) (Type, Pr	int)				2007	0		
	Stat		Barbara S		1500 FO	rest	Gien I	Road, Sil	ver S	bring		ZU91	.U		
	Stat Registra	~	SFI		O Registra	, A.	par								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 Pay SEPT 2010 SHEPARD 0415 a M WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs Social Security Numbe . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔯 M 2 🗆 F Months Days Hours Min (Month, Day, Yea 82 ľ927 Director Oct 39-40-771 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2103 Crepe Ct. 20721 USA 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1951-Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: 3 X Widowed 4 Divorced Black 1953 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Dept of Navy Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John E. Shepard Norah Batts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Shepard - Son 2103 Crepe Ct. Mitchellville, MD. 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Edgecomb Comm Cem 10-2-2010 Hampstead, NC . Signature of Funeral Service Licensee 22 Name and Address of Facility
Marshall-March Funeral Home 4217 9th St. NW Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, it also leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executability at hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of pe

(Month, Day, Year)

27

6+1

mpleted cause of death (Item 23a) (Type, Print)

D4547/ 9-24-2010 1111 Spring 5T Ste 214 Silver Spring, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 Physician/ Claiborne Steele Trott ŽÖ10 September 6:30 A M Medical 4c. County of Death Frederick 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Frederick Homewood at Crumland Farms -If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 2/09/1922 1 □ M 2 🕱 F 87 Director 577-26-1210 Usual Residence of Deceden ms 23a or 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick 1 ☐ Yes 2 💢 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7401 Willow Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Frederick Trading Elementary/Seconday (0-12) College (1-4 or 5+) Company <u>executive secretary</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Issac Steele Maria Randolph Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Trott / son MD 21702 10214 Bethel Rd., Frederick. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Rock Creek Cemetery 10/04/2010 Washington, DC 21. Signature of Funeral Service Licensee Keeney and Bastord PA Funeral Home Jagulie Mus MO1222 106 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and D. ath Immediate Cause (Final Physician/ STROKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pertension Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Month Day Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 K Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has performed? Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 V No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation To the Hospital or Attendential Within 24 hours after death To the Funeral Director; completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D43091 September 30, 2010 Toil Home Are, Frederich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Caria 31. Date filed (Month, rar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year September 5:58 A M James Carlyle Thweatt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suitland 4407 Rena Rd. Apt. 4 Prince Georges 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**XX**M 2 □ F Months Days Hours Min. 223-56-7332 Yrs 66 Director June Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2XXNo Suitland Maryland Prince Georges 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A 4407 Rena Rd. Apt. 4 20746 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 X No 'natural", or δ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2XXX No Specify. Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clergy Outreach Minister 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Thweatt Irene Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4407 Rena Rd. Apt. 4 Suitland, MD 20746 Lynnie Thweatt (Wife) 20a. Method of Disposition
1 ☐ Burial 2XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) Oct. 1, 2010 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shark, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: 1 🗌 Yes |@ 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: s after death. I Director: After t 28d. Describe how injury occurred 1 A Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral D Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0051194 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

SEP 29

Emerson Coronel, MDJ 5801 Allentown Road, #510, Camp Springs, MD 20746

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Americ#10f. PerFHPCC9-29-10cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>5</u> Month Year 0 Physician/ 09 04:45a M HADI TEHRANI Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE HOSPITAL ROCKVILLE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 □ F Months Davs Hours Min. 02/01/1959 IRAN **Director** 227792247 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland Director Examiner must be notified 28a-f 1 Yes 2 No MONTGOMERY GAITHERSBURG MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? (20882) 20882 1216 items 23a Funeral USA 6801 DORSEY RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ If Yes, Give Year or Dates 1 ☐ Yes 2√☐ No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) and Mental Hygiene. is marked other tha AUTOMOTIVE MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev once. ျှ MOHAMMAD TEHRANI ZAHRA SAYYAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 DORSEY RD GAITHERSBURG MD 20882 MEHRAFARIN TEHRANI -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 Cremation 3 Removal from State D9/26/201q ROCKVILLE MD 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN FUNERAL SVC. 22. Name and Address of Facility SERENITY 21. Signature of Funeral Service Licens 14640 FLINT LEE RD CHANTILLY VA 20151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
menth 5 Immediate Cause (Final Physician/ cancel ung disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has k lirector, page 2 s autopsy Yes 2 🗓 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🕦 No ည 1 Tes 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury 5 \square Pending 1 P Natural 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Joseph M. Heggertumo D32407 September 25, 2010

State Registrar

2010

5

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

9707 Medial Center Dr. Rodcille, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yı M.D. 9707 32. Registra'is Signatur

JOSEPH M. HALGERTY,

31. Date filed (Month, Day, Year) SEP 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07589 State of Maryland / Department of Health and Mental Hygiene **Bradley Timbrook** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0311 hrs October 3, 2010 **Medical Examiner** Timbrook 11 Bradley Clay 4c. County of Death 4b City Town or Location of Death 4a. Facilify Name (if not institution, give street and number) Cumberland Allegany 722 Virginia Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Oct.20,1985 Country) VA 24 Director 232-33-8640 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County 1 Yes 2 XX No Hampshire Romney hours after death with the Maryland Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 26757 **USA** HC-63 Box 3230 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 1 Yes 2 x No Specify: f Yes. Give Year 1 Yes 2 No specify: White 3 Widowed 4 Divorced ð 15. Decedent's Education (Specify only highest grade completed) 1ôa. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than 'traumatic event, the Medical permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that Law Enforcement Deputy Sheriff 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth A. Nelson Bradley Clay Timbrook 1 Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ 19a. Informant's Name/Relationship (Type, Print) Romney, WV 26757 HC-63 Box 3230 (mother) Elizabeth Timbrook 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/8/10 Mt. Dale Cemetery Shanks, WV 4 Donation 5 Other Specify 22. Name and Address of Facility 21 Signature of Funeral Service Licens ^{acility} McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 Approximate Interval is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complicati **Physician** Between Onset and failure. List only one cause on each lin ∠ /Medical Head and neck injuries Death xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED as noted, 23a,27,28a-f, per ME g910 12/7/10 TT the attending physician ed for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Year Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ò 1 Yes 2 No 3 Probably 4 Unknown Completed Records, s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? ✓ Yes 2 No 1 🗸 Yes 2 No this certificate Hospital or Attending Physician: '24 hours after death.'
Funeral Director: After this certifit 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? ^{28d. Describe} how injury occurred individual hit by train 27. Manner of Death Certification: 1 Yes 2 No 1 Natural Director: d in by the f Pending 10/3/10 3:11 am 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State)/22 Virginia AVE Cumberland, MD Could not be Suicide determined (Specify) train tracks Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number O.C.M.E. October 3, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar 31. Date filed (Month, Day, Year)

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 Pay 2010 11:20pM Patricia M. Turner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cheverly Prince Georges Prince Georges Hospital Social Security Number 8. Date of Birth $J_{une}^{(Month, Day, Year)} 1958$ If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F **Director** 220-70-8839 52 Yrs. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8210 Colonial Lane 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African Completed by 1 K Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: American 3 Divorced 4 Divorced ind Mental Hygiene.
s marked other than "natura
numatic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) P.G. School Board Monitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည rmit. Page 1 and 2 should be 1 partment of Health and Menta portant: If item 27 is marked y injury or other traumatic e Walter Bishop Turner Mary Haskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanisha Turner/ Daughter <u> 203 Gondar Ave. Landover.</u> MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I-Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 9/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD Part 1. Enter the dis shock, or heart failu ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or Indition Physician/ Medical resulting in death) opnsequence of) Examiner Sequer tially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and the attending physician and the for use as the burial-transit that initiated events Due to (or as a consequence resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No I Director, After this certificate has been signed by the rd in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖄 Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a d title of certifier 200 ress of person who completed cau use of death (Item 23a) (Type, Print) hever

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 24, 2010 Year Donald Emory Tillson 8:30 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 579-34-2610 83 **Director** N.C. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XNo Montgomery Rockville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 4700 Eades Street 20853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 200 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates. Specify: White WWII era 3 Divorced Completed 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking Be Maryland Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Henry Tillson Flora Emily Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Sinclair Tillson/Wife 4700 Eades Street, Rockville, MD 20853 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Sept. 28 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between tract intection Onset and Death h sician/ Immediate Cause (Final urihanu 0 da49 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list co. ditions, if any, leading to immediate cause. Enter Underlying Examine respiratory failure Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year sate has been signed by the a page 2 should be detached it g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 2 No Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 **N**O 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: s after death. I **Dire**c**tor:** After tl 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) Medical Center Dr. ichael 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thibadeau, Sr. SEPTEMBER 26, 2010 Tondorf 1633 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Regional Hospital Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min 04 Pay, Ye 1 😾 M 2 🗆 F 212-20-2010 87 1923 Washington DC Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20904 3148 Gracefield Road, # T-17 United States 12. Was Decedent Ever in U.S. Arraed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No Specify: Specify: White 3 - Widowed 4 X Divorced Year or Dates. WWII permit. Page 1 and 2 should be filed within 72 hour pepartment of health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medicine Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Baxter Thibadeau Marie Elizabeth Nies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Ladas / Daughter 13812 Bethpage Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 10/02/2010 4 Donation 5 Other (Specify) Gate of Heaven Cem. Silver Spring, MD 21. Signature of Funeral Service Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877 M00956 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ KIDNEY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 🛣 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier D 29282 1-26 2010

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

HERSHEY, PA 19044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27 2010

31. Date filed (Month, Day, Year)

BARRY SPECTOR, M.D., 100 WITMER DRIVE,

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

OCME

111-Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Day Year) 2010

Russell Alexander MD.

Assistant Medical Examiner

32 Registrar's Signatur

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	•	For State Registrar	State of M	aryland / I	•	irtment of F tificate of D	lealth and N Death		giene Reg. No	001	0 3	2120
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Funeral Director		5. Social Security Number 184–14–0867	F 7. Ag	e (In yrs. last birt 86	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 28	th y, Year) 3, 1	Co	rthplace (State ountry) nnsylva	
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ter c	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1		1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:		
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nd 2 shou lealth and m 27 is m		19a. Informant's Name/Relationship (in Adrienne Mickle	ype, Print) r/daughter	1.	463	Pleasant	Lake Ro		apol.	is, MD	21409	
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or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the broad the funeral director, page 2 should be detached for use as the broad the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	у			23d. Date of de Month	elivery Day	Year
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To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completed filled in by the funeral director.	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination and/o	or investi	gation, in my opinio	n, death occurred a	t the time, date a	and place	, and due to the	cause(s) and r	nanner stated.
To the within the comment of the com		29b. Signature and title of certifier	\			29c. License	16964		29d. Da	te signed (Mon	th, Day, Year)	010
104/		30. Name and address of person who		eath (Item 23a) (Type, Pi		13/0/	A	·	Q, m		21017
State		31. Date filed (Month, Day, Year)		ar's Signature	1	-cuce	Hwy	1/1/4	my	4	1) 6	
Registra	r	SEP 2 3 20	10 Steen	U A.	ba	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieriè

			1 - For State Registrar	State of Maryland		tificate of			eg. No.	32140
			Decedent's Name (First, Middle, Last)		1			2. Date of Deat Month		3. Time of Death
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4	Examin	er	4a. Fecility Name (if not institution, give s	street and number)		4b. City, Town, o	L .	ath	4c. County of De	inoll
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	II Under 24 H Hours Mi			irthplace (State or Foreign Country)
	Director		220-10-3309	M 2□F 87	Yrs.	Months Days	Hours IVII	Dec. 24	, 1922	MD
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Lo	cation		<u> </u>		10d. Inside City Limits
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examitme minst be motified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 □★No If Yes, Give Year or Dates:		Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)	Black, Wh	white
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Baltimore,	permit. Departn Imports any inju		21. Signature of Euneral Service License	Muna						ortuary, Inc. PA 17349
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Вох	attending for use		230. Was decedent pregnant	3c. If yes, outcome of pregnand		Ectopic pregnancy	,		23d. Date of d	
о. Ш	The law requires that the death cer ite has been signed by the attendin bage 2 should be delached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of dea 9 Unknown		Other (specify)			Month	Day Year
٥.	res that the de igned by the a be detached t	by Ph	Part II. Other significant conditions con	tributing to death but not result	iting in the un	derlying cause giv	en in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
rds	w requires been sign should be							1 □ Y€	es 200 No 3 🗆	Probably 4 Unknown
Records,	e law requ has been je 2 shoul	Completed						24a. Was a autops	v prior te	autopsy findings available o completion of cause of
								perform 1 Yes 2	ned? death No 1 ☐ Yo	es 20 No
Viital	s certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	B/Outpatien	t 3□ DOA Oth	OF:	eath <i>(Check only on</i> Home 5 X eside		agains)
Division of	Attending Physicien: or death. ector: After this certific by the funeral director.	-	27. Manner of Death 1 Matural 5 Pending		28b. Time of Injury	28c. Injur Wor	y at		w injury occurred	vocity)
Sio	tendir leath. tor: Af the fu	catle	2 Accident Investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No			
Σ	tel or Attendrs after deatlast Director:	Certification;	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, larm, stre	eet, factory, office		281. Location (St City or Town	reet and Number or . n, State)	Hural Houte Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerat Director: After this certific cumpletely filled in by the funeral director.	ledical	29a. Certifier 1 V Certifying Physic (Check only one) 2 Medical Examination (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tir restigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, di	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
3 3	To the	M	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
ŀ						D001	8892		10/6	10
		1	30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type,	int)	RA	Brokley	0.000	21120
Œ	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire &	barker	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day 22 Kevin Leroy ^Y201 Medical Watson 09 2:45AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21905 Yerkey Road Rock Hall Kent Social Security Number 6. Sex 1 ፟ M 2 ☐ F **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Director Months Days Hours 213-76-2331 03/18/1958 52 Maryland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 23a or 28a-f shoy 10a. State 10b. County event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Kent Rock Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21905 Yerkey Road 21661 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. Completed 3
Widowed 4 Divorced 1 ☐ Yes 2 K No Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Recieving Depart. Supervisor Vaulve and Coupling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည or other traumatic Walter Watson Miriam Porter Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JoAnn Watson - Wife</u> 21905 Yerkey Road Rock Hall, Maryland 21661 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wesley Chapel Cemetery 9/25/2010 Rock Hall, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home 130 Speer Road Chestertown, Maryland 21620 Enter the disease, or complications k, or heart failure. List only one cause at aused the deat o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death Physician/ **⊢** Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury burlal-tra that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No 23d. Date of delivery Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Month Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops perform within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medica 1 🗌 Yes Be 26. Place of Death (Check only one) Hospital: 2 No ျ 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice Per: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D0051786 ed cause of death (Item 23a) (Type, Print Rin 31. Date filed (Month, Day, State 2Eb/53 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09-28-20 PO **Physician** Harry Cairnes Ward 7:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 123 Francis Street Havre de Grace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 86 217-03-6558 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, it w Medical Experiment must be notified at once. Havre de Grace Maryland Harford 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Francis Street 21078 United States of America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 DYes 2 No If Yes, Give Year or Dates: WWJJ 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Ward Maude B. Gallion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Francis St., Havre de Grace, Maryland 21078 Cleo M. Ward (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Weslyan Chapel Cemetery 10-01-2010 Aberdeen, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 1 1 123 S Washington St. Havre de Grace, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) _/Medical Due to (or as a consequence of): Examiner ul monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ onary artery disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home Stresidence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certific D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6225, UNION AVE, HAVRE 40 State Registrar

For State Registrar

State of Maryland / Department of Health and Mental Certificate of Death	Hygiene ,	2	1	0
Certificate of Death	Reg. No.	J		U

32143

Physician
/Medical
Examiner

Director

with the Maryland r than "natural", or items 23a or 28a-f sho death filed within 72 hours after ar it. Pages 1 and 2 should be file er artment of Health and Montal H nportant: If item 27 is marked oth ny injury or other traumati: even per il Decar Impor anv in

Maryland

Physician /Medical Examiner

signed by the attending physician and be detached for use as the burial-tran Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director, p.

P.O. Box 68760

Division of Vital Records,

1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death ALFRED MOHR WEBB SEPTEMBER 22, 2010 2:52P.M. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Boonsboro Washington Reeders Memorial Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 30, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Pennsylvania 268-22-8554 96 Ĩ'914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√E No Director Frederick Myersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21773 3905 Highland Court by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 XNever Married 2 ☐ Married 1 ☐Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) U. S. Government Microbiologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Seese Charles ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Wallace Road, Troy, PA 16947 19a. Informant's Name/Relationship (Type. Print) Elaine Moyer-Davis/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hagerstown Crematory Sept.24,2010Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 tells 23a. Part1. Enter the dis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestine heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 🗘 lo 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID MAHMOOD, 580 NORTHERN AVENUE, HAGERSTOWN, MARYLAND 21742 301-733-4496 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gladys Anne White September 2010 8:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Hours Min Maryland 220-26-8475 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hyglene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a, State 10b. County Director 10d, Inside City Limits 1 🔀 Yes 2 🗌 No Fruitland Maryland Wicomico 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21826 300 S. Division St. USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Brittingham Plant Farm Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. ဂ္ Ralph Livingston Gladys Anne Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31993 E. Line Rd., Delmar, MD 21875 Alton T. White, Jr.|son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Allen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 09 27 2010 Allen, Maryland 21. Signature of Faneral Service Licensee Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician ENI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or se a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician the driving the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Dav Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performe Yes 2 No 2 No certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 힏 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After X Natural 5 Pending 1 Yes 2 No I Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours after To the Funeral Direct Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 9/24/ 61513 3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Mahesha Thimmarayappa M.D

SEP 28

31. Date filed (Month, Day, Year)

eaistrar's Sianatu

910 Easternshore Dr Salisbury MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 79897 September 27, 2010 Physician Georgeanna Shough Wachel 0135 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 East Cedar Point Drive Perryville | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Fo. Months | Days | Hours | Min. | March | 12,1932 | Pennsyl vania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 139-24-2045 Director 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f shov the Medical Examiner must be notified at Maryland Cecil 1 X Yes 2 □ No Director Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 East Cedar Point Drive 21903 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2V No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3√ Widowed 4 Divorced White Year or Dates: 16b. Kind of Business/Industry Penn Mutual Life Insurance Company Philadelphia, Pennsylvani 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) s marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F George Shough Abigail Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Importent: If item 27 Is any injury or other trau Janine Antoshak (daughter) 508 East Cedar Point Drive, Perryville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bala Cynwyd, 10/01/10 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery Pennsylvania 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kulmmany Disease Obstructive **Physician** years /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of): burialphysician cai the Physician/Med as t attending IF FEMALE nse 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death ò in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Munknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page perform certificate 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) P 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and tit of certifier 29d. Date signed (Month, Day, Year)

Box 68760,

P.0.

achdo VS MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDEV MD 126 A, E Fuigh ST

D0023322

ELKTON MD 21921

9.28.2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Larry Clayton Wagner, Sr. 2010 16, 2:29 a September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manchester 5201 Schalk Road #1 Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Pennsylvania 219-56-5205 59 **Director** Mar Usual Residence of Decedent show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Manchester Carroll Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 5201 Schalk Road #1 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decesor... Armed Forces? 1 ☐ Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Customer Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Wagner, Sr. Carrie Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Schalk Road #1, Manchester, MD 21102 Sharon Wagner, wife 20a. Method of Disposition Entombment

Disposition 2 Cremation 3 L Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other placerd Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important; If ite
any injury or ot
once. 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 9/21/2010 Evergreen Memorial Finksburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death 1 L Yes 2 L 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director; After this completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) e WIL 3848° 2010 cause of death (Item 23a) (Type, Print 30. Name and address 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $0.9^{\text{Month}}_{-2.3} - 2.0^{\text{Day}}_{1.0}$ 2214 Edward Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min $1^{\frac{(Month, Day, 1)}{-06-1}}$ 1 □**X**M 2 □ F 577-42-2793 Director 76 DC Usual Residence of Decedent or 28a-f show notified at 10b. County with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ems 23a or r must be r 10g. Citizen of What Country? Funeral 900 Varnum St., 20032 USA "natural", or items 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\,\text{t}\,h \end{array}$ College (1-4 or 5+ Truck Driver Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert Williams Ruth Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andre Williams/Son β901 Suitland Rd., Apt. 311, Suitland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/2/10 Suitland, Maryland 4 Donation 5 Other (Specify) Washington Nat. 20746 21. Signature Funeral Service Licenses 22, Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland, 23a. Part Nonter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a Cardio respiratory arrest Medical resulting in death) Due to (or as a consequence of) Examiner Anoxic Encephalopathy Sequentially list conditions, Examine cause (Disease or linjury Due to (or as a consequence of Cerebrovascular Accident Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial. Physician/Medical Atherosclerotic Cardiovascular Disease Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 □ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Renal Failure Stage VI 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed Advanced COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an + has autopsy performed? Ves 2 X N page 2 Coronary Artery Disease this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: မ 1 ☐ Yes 2 ☐XNo 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ To the I within 2 only one) 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 09/26/2010 47867 CR 2 ss of person who completed cause of death (Item 23a) (Type, Print) MD 4701 Randolph Rd., Suite 216, Rockville, MD 20852 Zuniga, 31. Date filed (Month, Day, State SEP 2 8 2010 Registrar

DHMH 17 Rev 7/2009

			for State Registrar		State of Ma		ertificate of F		/lental Hy	/giene Reg. 😡.	010	32148		
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Z,	1 and 2 Health a em 27 is other tra		Pamela Stev	enson –	Daughter		3 Queenswa		White			20695		
Baltimore, Maryland	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Dispositi 1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	emation 3 D l Other (Specify))	For	position (Name of ematory or other place t Lincoln	2010	Bı		d, Maryland			
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		/sicia		Virginia Wyati	F				2. Date of Dea Month	Day	Year	3. Time of Death		
		vledio camin		4a. Facility Name (if not institution, give street			4b, City, Town, o	or Location of Death	1 09		2010 ty of Death	15:20pm ^M		
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		eral		5. Social Security Number 6. Sex	24 F	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Cour	place (State or Foreign		
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Beltimore, Maryland 21215-0036	Page nent c	ıry or		1 X Burial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		natory or other pla incoln	10/	01/10	Blade	ensbi	ırg,Md		
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Division of Vital Records, P.O.	that the	d be detac	by Ph	Part II. Other significant conditions contribu	uting to death but not re	esulting in the u	ınderlying cause gi	ven in Part I.	23e. Did tol	bacco use con	tribute to th	ne cause of death?		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:15p M September Leon Wahrhaftig 2010 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15101 Interlachen Blvd., #908 Montgomery Silver Spring Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) If Under 1 6. Sex 8. Date of Birth Funeral 1 X M 2 D F 08/07/1927 Yrs Director 063-22-8366 83 Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15101 Interlachen Blvd., 20906 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 10 Black. White, etc Completed by 1 Never Married 2 X Married 1 Yes 2 X No should be filed within رو المحالة and Mental Hygiene. 1 ☐ Yes 2 No Specify: White 3 Divorced Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Government 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Yetta Reiner Isadore Wahrhaftig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 15101 Interlachen Blvd., #908. Silver Spring, MD20906 Betty Wahrhaftig - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) David Mem. Grdns 09/20/2010 | Falls Church, 21. Signature of Furieral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home. M0124 <u>|11800 New Hampshire</u> Ave., Silver Spring, MD 20904 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shork, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) Ing physician and sast less the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 凝 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 X No 1 Tyes Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D37142 September 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman. MD. 1355 Piccard Drive, Rockville, Maryland 20850

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEM LEX Bok Young Yang 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 **X** M 2 □ F Days Hours Min. S. Korea 75 270671935 218-96-6498 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director MD Prince George's Brentwood 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4149 Parkwood Court 20722 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Automobiles Mechanic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) r and Mental F is marked o 0 Page 1 and 2 should be f ment of Health and Menta ant: If item 27 is marked unk. Yang unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jung Yae Yang/Wife 4149 Parkwood Court Brentwood, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1

Burial 2 ☐ Cremation 3 ☐ Removal from State 9/27/2010 Silver Spring, Md. Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) Signature of PHINDEP ADSTRUMEDI FUNERAL SERVICE, P.A. 9241 Columbia BLvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition ARRHYTHMIA Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō 5 Other (specify) Month Day Year Pregnant at time of death ed by the 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? 2 🗆 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending ours after death.

neral Director: Af
filled in by the fu 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 1/A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL GRIFFIN Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32152 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marjorie I. Aidt Physician/ October 12, ^D2010 11:50 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Gilchrist Hospice 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs, 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 XX Months Days Hours Min. Sept 21, 1913 Director 97 214-14-2530 Usual Residence of Decedent 28a-f shor with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD N/A Baltimore YY Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 700 West 40th Street 21211 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: 3 ₩Widowed 4 □ Divorced "natural", Completed Specify: White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Supervisor 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles E. Thorn Grovie E. Whaley permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Joan Canapp (Friend)</u> Balto, MD 21211 3009 Chestnut Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 10/15/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HIP FRACTURE Ph sician/ COMPLICATIONS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic 5 Other (s. in the past 12 months? Day Year Pregnant at time of death the be detached g Unknow Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe 24 hours after death.

Funeral Director: After this certificate heleted filled in by the funeral director, paging 2 No 1 Yes 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) 🔊 Spice Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes ☐ Natural 5 Pending Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Fa11 2 Accident September 30, cup Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Home 3009 Chestnur AV, BALTIMORE MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the F 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTUBER 13 2010 D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N- Charles ST TONSON MD

DHMH 17 Rev 7/2009

State Registrar CHARIKS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3 2 1 5 3

			1 - State Registrar	State of Ivia	-	Certificate of		nu Meritai riy	Reg. No.				
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	Funeral Director		214-18-6746	ex 7. Age □M 2【X】F	y, Ye <i>ar)</i> 1, 1923	9. Birthplace (State or Foreig Country) Maryland							
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036	ba filed within 72 hours after death with the Maryland tal Hygiene. do other then "natural", or tams 23a or 28a-1 show event. The Medical Exercities and event. The Medical Exercities at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White				
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Maryland 21215-0036	should ba filed within of Mental Hygiene. Imarkad other than matlc event, than matlc event, than the matlc event.	To Be Co	17. Father's Name (First, Middle, Last) A.H. Wilson		00		18. Mother's Name (First, Mid						
	nd 2 sulth ar	19a. Informant's Name/Relationship (Type, Print) Ms. Madelyn Ball/ Daughter 19b. Mailing Address (Street and Number or 1028 Donington Circ							, Md. 212	204			
Baltimore,	permit. Pagas 1 as Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	()		Disposition (Name of y, crematory or other y Valley M	lem. 1	0-11-10	20c. Location - C	n, Md.			
Ra	permi Depa Impo any ir		21. Signature of Funey Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, In 1050 York Rd. Towson, Md. 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
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DIVISION	ital or Attenders after death al Director: led in by the	Certification:	3 Suicide 6 Could not be determined	286. Place of Injui					Street and Number vn, State)	or Rural Route Number,			
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			30. Name and address of person who	completed cause of de		Type, Print) NYIN	Tow	sor Ne	2 120	4			
	Sta Registi		31. Date filed (Month,-Day, Year) -	32. Recome	's Signature	hour							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland /	•	rtment of Health tificate of Death		ental Hygien	2010	32154
Physici	an/	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
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Exami	ner	JOHNS HOPKINS BAYVIE	·	ER	BALTIMORE	UM	, mp	BALTIMO	
Funeral Director		217-41-61701	7. Age (In yrs. last b)	irthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min.	8. Date of Birth (Month, Day, Year, 27,	965 PC	thplace (State or Foreign buntry)
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Daltimore, Maryliand Z IZ 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates.	lf '	as Decedent of Hispanic O Yes, specify Cuban, Mexica Yes 2	an, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify:	
13-U	Completed	15. Decedent's Edu (Specify only highest grade		(Give ki	ent's Usual Occupation and of work done during mo	st of workin	g	Kind of Business	4.0
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should and Me		19a. Informant's Name/Relationship (Type	9, Print) 19	9b. Mailing	Address (Street and Numb	per or Rural			p Code
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DallIIIIOI Dermit. Page 1 Department of mportant: If it any injury or o		1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		etory or other place)	10/15	1 10	A	stown, MI)
Definit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	naym	22. Ps	Name and Address of Facil	lity 27		to md.	Pass 21229
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Medical Examiner		resulting in death)	Due to (or as a consequence	,					Iweek
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requires been signatured	eted	NONE					1 Yes 2	<u> </u>	robably 4 Unknown topsy findings available
The law ate has page 2 to	Completed						autopsy performed?	prior to death?	completion of cause of
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 Yes No	spital:	<u> </u>	26. Place of Dea		only one)		<u> </u>
ding Physh.	ite: To	27. Manner of Death 1 ☑PNatural 5 ☐ Pending	1 Plipatient 2 ER/C 28a. Date of injury (Month, Day, Year) 28b.	Outpatient Time of injury	3 L DOA 4 L N 28c. Injury at work?		e 5 Residence 3d. Describe how inju		ify)
Attendii death. ctor: At	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, f		M 1 ☐ Yes 2 ☐		Bf. Location (Street a	nd Number or Ru	ral Route Number
ital or / urs after ral Dire		4 ☐ Homicide determined	building, etc. (Specify)			- 4	City or Town, Stat	e)	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Examine	ian: To the best of my knowledge r: On the basis of examination and/ Practioner: To the best of my know	or investig	ation, in my opinion, death of	occurred at the	ne time, date and plac	e, and due to the	cause(s) and manner stated.
To th withi To th		29b. Signature and title of certifier	x Al man		29c. License number		29 d . D	ate signed (Month	n, Day, Year)
61		30. Name and address of person who con	npleted cause of death (Item 23a)	(Type, Pri	RES-00	0 0	00	tober 11	0,2010
5 V		SAIAH SHARFSTRIN 31. Date filed (Month, Day, Year)			HENUE BA	LIMOR	2E, MD	21224	
Sta Registr		OCT 1 4 201		1	aire				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Items 25tate of Maryland / Department of Health and Month Hygiene

Certificate of Death

Reg. N 2 0 1 0 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Brogden Physician/ Month 2010 0234 AM ٥Ì Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Johns Hopkins Bayulew Medical Center Bautimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day 15) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral (** M 2 □ F Months Country) MD Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director Ba Himore Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? altimore 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18-Mother's Name (First, Middle, Maiden S ျှ 10 C Informant's Nar 19b. Mailing Address (Street and Orreacte Baltimore, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Location - City or Town, State cemetery, cremetory or other place) 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fun I Service Licensee 101553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Att. Inding Physician: The law requires to the lowns after distribution. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 **X** No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: Certificate: To 1 X Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗆 No Investigation Accident after death 2 Accident
3 Suicide
4 Homicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DO018684 october 1,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestma 152N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racket Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O'CT. 1:50 P M 2010 Divens Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore ndallstown If Under 1 Year 1 If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 M 2 Months 3^{Monto}Day,1930 80 Director Usual Residence of Decedent 28a-f shov 10b. County traumatic event, the Medical Examiner must be notified at State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No HONOVE 9 10e. Street and Numb 10g. Citizen of What Country? 23a21215 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married or ģ 2 **X**010 Yes Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗫 o Specify: "natural", 3 Divorced Completed ack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) omestic omes Be 18. Mothers Name (First, Migrate, Maiden Surname, ပ lone_s . Informant's Name/Relationship (Type, Print) 617 OND 21208 27 Mother or other item 20a. Method of Disposition

1 → Burlal 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place) Location - City or Town, State Department of F Important; If ite any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Lice 100 Pilce 23a. Part 1. Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Atherosc Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of).() Due to (or as a consequence of): resulting in death) Last the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No Month Day ed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tyes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗓 No Division of Vital director, Be 26. Place of Death (Check only one) Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Work: 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 113 D32158 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Jyotin suite 407 steer 2 My 2 /20/ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Robert Clarence Baker Medical October 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Thomas More Nursing & Rehab. Hyattsville If Under 1 Year 8. Date of Birth (Month, Day, Year) 06–24–1943 Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min **Director** 242-70-3203 North Carolina Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1X Yes 2 ☐ No DC Washington 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 32 Bates Street, NW 20001 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. filed within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 'natural", Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Private 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Baker Ardelia Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. Ada Baker — Sister 112 S Street, NW Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ŧ 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 10-15-2010 Brentwood, Maryland re of Funeral Service Lice 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Maryland Part 1. Enter the disease, or comication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e cause on each line. aryng Immediate Cause (Final Physician/ disease or condition resulting in death) ens Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter ordenying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 as t IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ģ Month Year Dav detached Unknown a 🗌 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signe Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed certificate 1 🗌 Yes 2 🔀 No Hospital or Attending Physician: 24 hours after death. **Division of Vital** funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No M Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person

Date filed (Month, Day,

DHMH 17 Rev 7/2009

4203 Quanssone

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

0

October 13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:43 P Janet C. Brittingham Physician/ Month October 11 Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Feb 27. 1931 1 M 2 Director 213-28-4209 Yrs Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD 1XX Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1413 Medfield Avenue 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1:43 p.m. ō 1 Never Married 2 Married 3 Widowed 4 Divorced Completed by 1 ☐ Yes 2XX No If Yes, Give XX No 21215-0036 1 ☐ Yes 2 XNo Specify. "natural", Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ဂ္ဂ William Howard Gardner Jessie Delilah Redman Jermit. Page 1 and 2 st.
Department of Health an.
Important. If item 27 is n.
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Brittingham (Husband) 1413 Medfield Avenue Balto, MD 21211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State OCTOBER 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 10/14/2010 Loudon Park Cemetery Balto, MD 22. Name and Address of Facility 2631 Falls Road Burgee Henss-Seitz Funeral Home, Inc Funer / 21. Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 **X** No Day Year Pregnant at time of death been signed by the 9 Unknown Unknown BRITTINGHAM Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed: Director: After this certificate 1 ☐ Yes 2 ☐ No JANET filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 **X** No Other: 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending X Natural work? 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours after To the Funeral Dire City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, TIMONIUM, MD 21093 CRNP 2300 DULANEY VALLEY RD. Date filed (Month, Day) 32. Registrar's Signature State 1 4 2010

Registrar

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10/18/10

22. Name and Address of Facility CAPITOL MORTUARY

1140 LALAANDE PL ANCHORAGE, ALASKA, 99504

20c. Location - City or Town, State

UTAW, ALABAMA

23d. Date of delivery

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Approximate Interval Between Onset and Death

Completed Be 2 WILLIE

Director

Funeral

þ

1 - For State Registrar

10a. State

MD

20a. Method of Disposition

Signa

19a. Informant's Name/Relationship (Type, Print)/SISTER

SHIRLEY JOHNSON-SHADBOLT

1 XBurial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

of Funeral Service

Physician/

Medical

Examiner

Funeral

Director

of Heatth and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> Department of Important: If it any injury or o jo :

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

> attending physician and for use as the burial-transit within 24 hours after death.
>
> To the Funeral Director: After this certificate! filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

1425 MARYLAND AVE., NE WASH., DC 20002 or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. I wisselectic Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (pres a consequence of Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Miknown Completed 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BELUAH BAPT., CH

State Registrar

Medical

29a. Certifier

31. Date filed (Month,

3 🔲

30. Name and address of person who com-

29b. Signature and title of certifier

eted cause of death (Item 23a) (Type, Print

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Valerie A. Bennett October 10:12P ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 221 Perrywinkle Lane Gaithersburg Montgomery Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, 1 □ M 2 🔀 F Days Min Director 54 1956 186-48-6359 May Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20878 214 Beckwith Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Available Helen Anita Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 214 Beckwith Street, Gaithersburg, MD Philip Bennett/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 14 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) All Souls Cemetery 2010 Germantown, MD 22. Name and Address of Facility Robert A. Pt Rockville, Inc. 300 West Mc Rockville, Maryland 20850 Signature Foreral Service License Pumphrey Funeral Home/ Montgomery Avenue 0-2805 M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Metastatic Pancreatic Carcinoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month Year 5 Other (specify) 1 Yes 21 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 X No 2 No 1 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Daughter's Residence Hospital Other: 1 ☐ Yes 2 🔀 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie

State

rac

M.D.

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

abert

Robert H. Gerard,

29c. License number

D0055522

1500 Forest Glen Road, Silver Spring, MD

29d. Date signed (Month, Day, Year)

October 11, 2010

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day РМ <u>Donna L. Bliss</u> 4:50 /Medical OUTOBER 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Sunrise Assisted Living Severna Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Director 1919 Maryland 220-09-5957 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Instit If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "nature in the Mary or other traumatic event, It a Marical Examination must be notified at any or other traumatic event, It a Marical Examination. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐Yes 2 ☑ No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 781 Dividing Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify: white Specify. 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Secretary/Manager Plant Tabs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mollie Heinritz ၉ Raymond Lveth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pers. permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr <u>Dr. Colen C. H</u>einritz Rep. 781 Dividing Road; Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State WABurial 2 ☐ Compation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulanev Valley Mem Gardens 10/16/2010 Timonium, MD 21. Signature of Fun ral Se vice pense 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one care on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) **Physician** Advanced /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 **2** Ño 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed/ certificate 2 No 1 ☐ Yes 2 Z No 1 ☐ Yes e Hospital or Attending Physician: 7 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

May Millervice My 21108

30. Name and address of per on who completed cause of death (Item 23a) (Type, Print)

Day, Year)

60

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 8, 2010 Year Physician/ Agnes **Brooks** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 401 Hawthorne Road Baltimore 8. Date of Birth (Month, Day, Feb. 19 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 💢 F Days Hours Min. 271-32-7141 Director 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director must be notified 28a-f s Vermont Addison Ripton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 Funeral P.O. Box 140 05766 U.S.A. and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items the reaumatic event, the Medical Examiner may Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Veach Lucille Andrews Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. 401 Hawthorne Road Baltimore, Maryland Thomas V. Brooks 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) 10-16-2010 | Ripton Vermont Cooks Cemeterv Funeral Service Licensee Signator 22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phyttician/ Non-small disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Dire to (or as a consequence of): Examir ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 1 Yes 2 2 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of perform Yes 2 X No Division of Vital filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence Son's Residence Other: 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier DO061040 Professor of Oncolog. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John, (topkin, Hospita)

Charles Land, Moffed 40: N. Broad and Are

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

Inc.

Approximate
Interval Between
Onset and Death
2 5 Mo

Year

Day

death?

1 Yes 2 No

21204

Ohio

White

9:25 P M

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) _

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 <u>Thomas Milton Beaufelter,</u> 4:20 Р Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Gilchrist</u> Center Towson 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Hours July 13, Year 1936 Baltimore, MD 216-32-3753 74 Yrs **Director** Usual Residence of Deceden show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21204 812 Loyola Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 \sum No
If Yes, Give Year or Dates 1954-1956 Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BG&E Electrical Designer Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Mildred Brooks permit. Page 1 and 2 should be Department of Heaith and Meni Important: If item 27 is marke any injury or other traumatic. once. George Beaufelter traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2329 Eastridge Road Timonium, MD 21093 Thomas Beaufelter, Jr. /son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Hilltop Service Corp.:10/08/2010 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset on 10 oth Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has be page 2 s autopsy perform death? certificate 2 🗌 No 1 Yes ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ၉ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death.

e Funeral Director: Aileted filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nancy Barbara Clute October 2010 9:08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. Citv. Town, or Location of Death c. County of Death
Baltimore Stella Maris Hospice Timonium . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours July 29 050-24-6122 Yankers, New York ^{Year)} 1930 80 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Glen Arm 1 🗆 Yes 2 🎽 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country United States 23a Funeral 4515 Long Green Road 21057 America items ; death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: than "natural", 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Circulation Clerk Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Balint Agnes Suspliski OCTOBER 13, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat Mr. Ronald W. Clute/ husband 4515 Long Green Road Glen Arm, Maryland 21057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State October 15. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Episcopal Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Long Green, Maryland 21. Signature of Mineral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year as been signed by the 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sinn Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown CLUTE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page performed 2 🗌 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medica examiner? a B 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖫 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES,

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

TIMONIUM.

MD 21093

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month. Dav. Year)

ORIGINAL

who completed cause of death (Item 23a) (Type, Print)

32. Registare Signature

29c. License number

Drive Charter MD 21619

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Healthand Mental Hygiene

Certificate of Death

Reg. N 2 0 | 0 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Audrey L. Carter Oct. 11 2010 5:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 8. Date of Birth 1937 9 (Month, Day, Year) July 29, 2010 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min. 1 ☐ M 2 ☐**X**F Months Hours 213 32 4062 Country) MD Director Yrs. 73 Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Randallstown 1 X Yes 2 □ No 10e. Street and Number è 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 18 Bannock Ct. 21133 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Self Employed Packaged Goods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Howard Olney Goldie Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ezekiah (Zeke) Carter (Husþand 18 Bannock Ct. Balto, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 27ate Oct. 19, 201 Vet. Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Garrison Forest OwingsMills, Md. ignature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ WORIAM disease or condition C ance ontu Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year signed by the at Id be detached for ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ trombo Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 2 🗌 No 2 **X**INO 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 မ Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nospice Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 No after death

Director: A

d in by the f Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier OCPOSER 11 ZOLO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson mo HARVES 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Delano a.M 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
Oct. 2, 1950 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours Min. Months 216-54-3847 Director 60 Vrs Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified MD N/A 1 x Yes 2 No Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 5021 Pennington Avenue 21226 USA items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates, Black, White, etc ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white "natural", 3 Midowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouseman Warehouse Be . Page 1 and 2 should be filed ament of Health and Mental Hys 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Archie Miles Delano Jeanette Lafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Stacey Delano-Daughter 5021 Pennington Ave. Baltimore MD 21226 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) 1 Burial 2 ACremation 3 Removal from State Atlantic Crematory Oct.13,2010 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Rome Inc. 21. Signature of Funeral Service Licen 1328 Sulphur Spring Road Arbutus MD 21227 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a co sequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence oi). it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi Hospital or Attending Physician; The law requires that the death certificate be execute Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Pregnant at time of death Day ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Be Completed 1 ☐ Yes 2 ☐ No plnous . Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe After this certificate 1 🗌 Yes 2 🗀 No Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 2 No Accident 24 hours after deatl Funeral Director: Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the property of the basis of examination and/or investigation in the basis of examination and or investigation and or investigation and or investigation and or investig completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HUUTOTAG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 4 2010

Robert

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Daugherty Kathleen Gladys Oct 1:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 9232 North Howard Avenue Fort Howard Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. II, 1925 6. Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 X Hours Virginia **Director** 225-22-4915 85 Oct. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must he matter and 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick 1 ☐ Yes 2 ☑ No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14213 Black Ankle Road 21771 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Years Manufacturing Wireman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Landon Isiac Hall Martha Ann Via 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Skoczelak 14213 Black Ankle Road Mt. Airy, MD (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Glen Haven Cemetery 10/15/2010 Glen Burnie, MD 21. Signature o Funeral Service Lenses Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OVARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contificate to the Funeral Director: After this contificate for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months2 Month Pregnant at time of death Dav Year 5 Other (specify) should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Daughter's 26. Place of Death (Check only one) examiner? Hospital 2 🖾 No Other: ျှ 1 🗌 Yes Residence 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 055306 S MO

Registrar

DHMH 17 Rev 7/2009

State

9106 CHICADELPHA

Sufe 200

BALD. NO 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-H. ODLE MO

DENNIS -H · 8
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		ertificate of D			Reg. No. 2010	32169
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	W	Do	HLER		2. Date of Dea Month	Box Voor	3. Time of Death 02i M
	Examin		4a. Facility Name (if not institution, give si 592 Forest View l			4b. City, Town, or Lint	ocation of Death		4c. County of Dea	rundel
	Funeral Director			7. Age (<i>In yr</i> s 82	. <i>last birthd</i> ay Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 06/13		irthplace (State or Foreign cunty) aryland
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		City, Town or					10d. Inside City Limits
	the Mar a or 28a be notifi	Funeral Director	Maryland Anne A		Linth	10f. Zip Code			10g. Citizen of What C	1 ☐ Yes 2 💆 No country?
	eath witl tems 23 er must	Funera	592 Forest View	12. Was Decedent Ever in U	J.S. 13	21 B. Was Decedent of Hisp If Yes, specify Cuban,	1090 panic Origin? (Sp	ecify Yes or No-	U.S.A.	erican Indian,
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates.		If Yes, specify Cuban, 1 ☐ Yes 2 A No		Rican, etc.)	Black, Whi	
Maryland 21215-0036	in 72 hou e. nan "nati Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation e completed) College (1-4 or 5+)	(Giv	redent's Usual Occupat re kind of work done du DO NOT use retired)	tion tring most of work	ing	16b. Kind of Business	
ld 21	iled with I Hygien o ther th /ent, the	Be	12th 17. Father's Name (First, Middle, Last)		M	anagement	18. Mother's Nam	ne (First, Middle, i	Brick R Maiden Surname)	efractory
ıylar	should be f and Menta is marked raumatic ev	To.	19a. Informant's Name/Relationship (Type	Harry Dohler	1			retta Re		
	and 2 shou Health and tem 27 is m other traum		Deborah Sue Murra	ay / Daughte	r 703	iling Address (Street an 3 Swain Dri			a, Virgini	
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	cemetery, cr	position (Name of rematory or other place) i11 Cemete:)	Date 11/2010	20c. Location - City o Baltimore	r Town, State , Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee			22. Name and Address	of Facility G	once Fur	eral Servi	ce, P.A. ryland 21225
			23a. Part 1. Enter the disease or complication of the shock, or heart failure List only one immediate Cause (Final	cations that caused the dea	ath. Do not er					Approximate Interval Between O et and Death
ا درستان	Medical Examiner		disease or condition resulting in death)	Due to (or as a consec	quence of):	my st	ruce	*		y let and Deali
		ner	Sequentially list conditions, if any, leading to immediate		quence of):	MM	rten	n		glun
0	xecuted n and al-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
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Box bg	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral alrectors After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of g Unknown	tal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year
7. O.	s that th gned by be detac	<u>م</u>	Part II. Other significant conditions conf	ributing to death but not re	esulting in the	underlying cause giver	n in Part I.		bacco use contribute to	_
ords	w require s been si should	Completed						24a, Was a	n 24b. Were au	Probably 4 Unknown
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VITA	hysiciae this certii al directo	P B	examiner? 1 Yes 2 No	ospital:		ent 3 DOA Other:			ence 6 🗆 Other (Spec	cify)
0 0	ending F sath. or: After I he funer	Certificate:	27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time injury	work?	es 2 🗆 No	28d. Describe ho	w injury occurred	
Division of Vital Records,	ial or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia		treet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
:	ne Hospi n 24 hou ne Funeri	Medical	(Check 2 <u>Medical Examine</u>	ian: To the best of my known: On the basis of examination	on and/or inve	estigation, in my opinion,	death occurred at	: the time, date an	d place, and due to the	cause(s) and manner stated.
	Vithi To the	— г	29b. Signature and title of certifier	A		29c. License n			9d. Date signed (Mont	
	2541	Ī	30. Name and address of person who con	11 - 1	m 23a) (Type,	Print) EFENSEHW	A ANA	VAPOLIS	WO WINED	0 / 0 0 0
	Stat Registra	-	MICHAEL Si Ce. 31. Date filed (Month, Day, Year) BCT 1.4 201	32. Registrar's Signa		2	1 11144	- 0 1 - 0 - 1	7740/	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Vahnie 25: /Medical 10 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death der 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗷 Months Days Hours Min. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits if than "natural", or items 23a or 28a-f shitte Medical Examiner must be rediffed. Kandal Director 1 ☐ Yes 2☐ No Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any injury or other traumatic event, the Magnote. Elementary/Secondary (0-12) College (1-4or 5+) OFFICER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname, lliam laitman ဥ 19a. Informant's Name/Relationship TVIS DanKS - U 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Reisterstown, mo 21136 Manor RD 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Gremation 3 ☐ Removal from State Arbutus, 4 ☐ Donation 🔊 ☐ Other (Specify) 21. Signature of neral Service Livensor 23a. Party Epiter Indiasease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or indition resulting in death) **Physician** MORE TITU -me /Medical Due to (or as a con requence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if an, leading a immunication cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: nse yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 in the past 12 months? Month Year Day ☐Yes 2☐No 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate of Vital 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2No 1 Mnpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural Injury death. after death Director; A 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature OCT 14 2010 June S. Again State Registrar

DHIME OF BOY DOOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a, pt.11,26 per doc g908 10-14-10 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct ľð 20°10 16:32 P M Charles Pinkney Eaves Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MO **Funeral** Min month, Day Year 2 1 5√2 M 2 □ F Hours Director 357-24-2295 78 Apr Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severn 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1219 Old Camp Meade Road 21144 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Divorced 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) US Army Staff Sergeant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Felix Calvin Eaves Maybel Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Anita Eaves/ wife 1219 Old Camp Meade Road Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2010 Meadowridge Mem. Park Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funera Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Monzi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ (ADIONY ONATH JOHNIC 10 years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Securitially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ DISCARE Chronic Obstrative 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes autopsy perforn 1 Yes 2 No 2 1 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 - No Other: ပ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 24 hours after death Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 11326669 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Young - Hymnn; 7845 OAK WOUND OAKWOOD NO + 106 Cley Surrie MD 21061. 6 31. Date filed (Mo State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fortune Doto by 11:45A M **Physician** lizabeth 12,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month)Day, Year | Min. | 07/17/1/926 Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 249-38-5665 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No If item 27 is marked other than "natural", or items 23a or 28a.f sho or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 6 Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Tailor 18. Mother's Name (First, Midgle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ဂ္ Department of Health a Important: If item 27 is any Injury or other trainone. 20a. Method of Disposition Woodford 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat e of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Kupture of thoracic abdominal Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical filled in by the funeral director, page 2 should be detached for use as the IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Woknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes s after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral L 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 12, 2010 RFS-000 30. Name and address of borson who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Mitchell Fitzgerald, Sr. October9 2010 1:47 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Baltimore Pikesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Month 12/1931 79 218 26 6253 Director Virginia Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Somerset Maryland Princess Anne 1 Tes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10453 Clarence Barnes Road 21853 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

Yes 2 \(\) 10948-Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates. 1950 3 Nidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Home Improvement Contractor Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James G. Fitzgerald Dorothy B. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Fitzgerald 200 Willow Lane Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2010 Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tree. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s performed? Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural iniurv 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi License number mesting 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 2300 Dulaney Valley Road Timonium, Maryland 21093 Dr. Ernestine Wright 31. Date filed (Month, Day, Year strar's Signature State

Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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24a. Was an autopsy finding prior to completion or death? 1	ery Av
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29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	25)
29b. Signature and title of certifier 29c. License number O.C.M.E. October 4, 2010	ar)

State Registrar

Ling Li, MD

31. Date filed (Month Car, Year 2 2010

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIE D. GREENE October 6,2010 12:10AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death LANHAM4c. County of Death PRINCE GEORGE'S **Examiner** DOCTOR'S COMMUNITY HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 | F Days Hours Min. 244-78-1164 Country) 61 Yrs. **Director** 3/1949 CAROLIN Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD PRINCE GEORGE'S CAPITOL HEIGHTS 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5615 ADDISON RD 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Department of Heath and Mental Hygiene. Important: If tem Z7 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Black, White, etc. þ 1 √ Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify SpecifyBLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired during most of working Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE CHEF COOKING 12thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be HOWARD GREENE BESSIE M. McNEIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. GREENE/WIFE 5615 ADDISON RD. CAPITOL HEIGHTS, MD 20743 20b. Place of Disposition (Name of U.S. pemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) re of Funeral Service Li 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., DC 20002 23a. Part 1. Enter the disease or shock, or heart failure. List complications that caused the death. Don't enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Onset and Death Physician/ ARDIOPULMONAVY disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Dav Year 2 🗌 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Right hemithorax Dissere to 1 Yes 2 No 3 Probably 4 Unknown Anemia of chronic Ineoplate Dissus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has Fever perform 2 X No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 잍 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my kn, who are the cause of the cause o (Check Certifying Nurse Practioner: To the b 29d. Date signed (Month. Day. Year) mPD52865 2010

Registrar

Glenn Dale, Maryland

Road, Ste 200

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annapolis

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:30 AM October 12, 2010 John Drew Godsey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg Asbury Methodist Village If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 X M 2 □ F Days 411-46-0258 88 October 10, 1922 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1 X Yes 2 □ No Director Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ò 20877 United States 333 Russell Avenue, Apt. 406 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ٥ WWII 1 ☐Yes 2 🛛 No Specify: White þ 3 Widowed 4 Divorced "natural", Completed er than "natura". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Professor of Theology Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Theologian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lynn Corns 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Emalee G. Murphy / Daughter 5211 White Flint Drive, Kensington, Maryland 20895 27 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 13 Montgomery Crematorium, Inc Bethesda, Maryland 2010 21. Signature of Funeral Service Lizensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. Lette Dava ist M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) caronary undrome **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate RA 1 ☐Yes 2 ☐ No 1 ☐Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) of Lau 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 201 RUSSELL AVENUE GAITHEASBURG, MIS 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 14. RUBERT

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 16, 2010 Robert Α. Guest 7:29 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21199 Kent 1 historon Md 21620 owa If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 1 **X** M 2 \square F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Hours 139-26-9286 1070171935 PA 74 Director Usual Residence of Decedent 23a or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Chestertown Kent 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21199 Iowa Avenue 21620 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72.1 th and Mental Hygiene. ?7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Carpenter Õ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 21199 Iowa Avenue, Chestertown, MD 21620 Lisa Coppage - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) in state 6 any injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board, 655 W. per DVR / Ronald S. Wade, Director Baltimore Street, Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death IOmm VKS Immediate Cause (Final Physician/ carcinoma of disease or condition resulting in death) on-Small ce Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a ld be detached for Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Or the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 death? Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D0017036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Washington Age. Chestatown Md 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ BRONYA Medical 4a. Facility Name (if not institution, give street and nu Examiner SINAI HOSPITAL Social Security Number Funeral 1 M 2 F Director 218-49-8424 Usual Residence of Decedent 10a, State 10b. County Examiner must be notified at Directo 28a-f N/A10e. Street and Number items 23a Funeral 4205 FALLSTAFF ROAD permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Dec Armed F 1 Yes If Yes, G 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Completed 3 Widowed 4 X Divorced Year or I 15. Decedent's Education (Specify only highest grade completed Elementary/Seconday (0-12) 12 College

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= State Registrar					C	ert	ificate	e of E	eath			Reg.	NoO O	10	22	170
1. Decedent's Name	e (First, Middle	, Last)		-							2. Date of De	_	20	1 0	3. Time c	of Death
BRONYA			GOR	OBETS	5						OCTOBE	R I	Day 20	Year 10	5:44	4 A M
4a. Facility Name <i>(if</i>	not institution,					П	4b. City,	Town, or	Locatio	n of Death			4c. County			<u> </u>
SINAI H	HOSPITA	L					BA	LTIM	IORE				N/A			
5. Social Security N		6. Sex	7. Age	(In yrs. la	st birthda		If Under			er 24 Hrs.	8. Date of Bir			g. Birth	place (State	or Foreign
218-49-8	3424	1 □ M 2 F		83	Yrs	š.	Months	Days	Hours	Min.	03/15/	192	7	Cour	UKRA	AINE
Usual Residence of	i e															
10a. State	10b. County			10c. City	, Town or	Loca	ition								10d. Inside C	
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10e. Street and Nun	nber						10f. Zip	Code				10g.	Citizen of W	hat Cour	ntry?	
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11. Marital Status		12. Was Dece Armed Fo		er in U.S	. 1	3. Wa	as Deced	ent of Hi	spanic C	rigin? (Spe	ecify Yes or No- Rican, etc.)				can Indian,	
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17. Father's Name (I	First, Middle, L	ast)							18. Mo	ther's Nam	e (First, Middle,	Maid	en Surname)			
MOTTEL			GI	REBEN	1				RA(CHEL			UN	KNOW	N	
19a. Informant's Na	me/Relationsh	ip (Type, Print)		_	19b. Ma	ailing	Address	(Street a	nd Num	ber or Rura	al Route Numbe	er, City	or Town, St	ate, Zip (Code)	
YELENA	GOROBE'	rs/daught	ER		42	205	FAL	LSTA	FF I	ROAD,	BALTIM	ORE	MD.	212	15	
20a. Method of Disp				20b. Pl	ace of Dis	sposit	tion (Nan	ne of			Date	_	. Location -	City or To	own, State	
1 🔀 Burial 2 l 4 🗔 Donation		3 Removal from	State		metery, c					10/	11/2010		BALTI	морг	MD	
21. Signature of Fur				111111	11010											
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shock, or hear	rt failure. List o	nly one cause on ea	ch line.	ille dealli	. Do not e	siitei	the mode	a or dying	, such a	s cardiac c	or respiratory ar	rest,			Approxima Interval Be	tween
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in the past 12 g	norths?	1 ☐ Live 4 ☐ Preg	Birth 2	Fetal	death 3		Ectopic p Other (sp		/				23d. Date Mon		-	Year
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Part II. Other signifi	icant condition	ns contributing to d	eath bu	t not resu	Iting in th	e uno	derlyina a	ause aive	en in Pai	t I.	23e Did to	obacc	o use contril	aute to ti	ne cause of c	death?
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25. Was case referre	ed to medical							26. Pla	ce of De	ath (Check		۷ ا	INU	65	2 LI NO	
		La contraction								, 5,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						

Physician/ Medical Examiner

> the attending p for use as t

page 2 should be detached

pleted filled in by the funeral director,

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To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

by

Completed

Be

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Certificate:

Medical

IF FEMALE:

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

23c.	If yes,	outcome	of pr	egnancy

25. Was case referred to medical 2 40 1 Yes

Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 - Residence 6 Other (Specify) 28b. Time of

27. Manner of Death 1 Natural Accident
Suicide

4 Homicide

29a. Certifie

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

Hospital

injury

28c. Injury at work? 28d. Describe how injury occurred 1 Yes 2 No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and

determined

29c. License number D 5 922

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Gould 2010 Beatrice B. 3:35 Medical AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 XF Year 1912 Months Hours Min. Nov. 24 Director 216-09-6041 97 Pennsylvania Usual Residence of Deceden 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore Timonium 1 🗌 Yes 2 🛛 No 10e. Street and Number ö 10f. Zip Code the Medical Examiner must be 10g. Citizen of What Country? Funeral with 23a 2300 Dulaney Valley Rd. 21093 USA items death \ 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏿 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Black, White, etc. 1 Yes Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Important: If item 27 is marked other than " any injury or other traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Thomas Balducci Catherine Faber OCTOBER 10, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas Gould/ Son 2505 Ridgeview Drive Forest Hill, Md. 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ᇹ 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Moreland Memorial Pk. 10-14-10 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Ruck Towson Funeral Home, 21. Signature of Funer Service License 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition CEREBROVASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Little Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Pregnant at time of death Month Day the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, BEATRICE Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 🗶 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Afortpleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 👿 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title

JACKIE JONES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 530 P.M Ruth E. Howard 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Breso Gallo Cut Arlington West Nursing Home UD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, 1 □ M 2 🕱 F Months Days Hours Min. Director 1910 North Carolina <u> 218-01-0222</u> Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f showner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Gwynn 0ak Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 3308 Fieldview Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23. by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 the Medical Exergi 'natural", or 1 ☐ Yes 2XINo Specify. Specify: Black 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Heatth and Men Important: If item 27 is marker any injury or other traumatic (Winslow Nixon Mariah unk ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul S. Howard, Son 3308 Fieldview Road, Gwynn Oak, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 10/14/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liberate of the injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural the Funeral Director; A death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

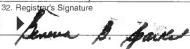
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Reg

Penhurest

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Dauto

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G908, 10/19/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 8:41 A M **Physician** 10 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore Horizon Assisted iving If Deder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 04 07 9. Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I've Medical Eventher must be notified at Baltimore 1 ☐ Yes 2 No Director $\mathsf{M}\mathsf{D}$ 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other tranment. Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Public Schools ecretar 18. Mother's Name (First, Middle, Maiden Surname 17. Fathers Name (First, Middle, Last, Be ouise Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, RaHiMore Koad 3altimore, 20b. Place of Disposition (Name of cametery, compatibly or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 4 Donation 5 Other (5 3 Removal from State 5 ☐ Other (Specify) f Funeral Servi 10re, Maryland 21212 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOVACUAR **Physician** HTHEROSCLEROTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760. attending physician be Physician/Medical as the IF FEMALE nse s yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the a P.O. 9 I Inknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown STAGE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D00605-60 OCTOBER 13,2010 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w 9106, Yh PHILADELPHIA RY #208, BALTIMORE, MI) 31. Date filed (Morth, Day, Year) 32. Registrar's State 1 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 13 2010 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE N/A BAYVIEW MEDICAL 8. Date of Birth (Month, Day, Year) Aug. 19,1926 If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Months 1□ M 2 5 Hours 213-62-3899 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 XNo Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Pinewood Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wolfkill Naomi G. Bay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Hanlin 9908 Maidbrook Road Parkville, MD (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/Other (Specify) 4 ☐ Donation wn Cemetery 10/18/2010 Baltimore, Maryland ture of ral Service Lights 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final MYOCARDIAL LICHEMIA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

MD

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

within 72 hours after death

d 2 should be filed w h and Mental Hygien 7 Is marked other th

nt of Health a

permit. Page Department o Important: If any injury or

Pages

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

or other traumatic

Baltimore, Maryland 21215-0036

attending properties of the second page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

resulting in death)	Due to (or as a consequence of):	40		0 0 17
Sequentially list conditions	, , , , , , , , , , , , , , , , , , , ,	TIC VALUE S	TENOSIS	2 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
that initiated events resulting in death) Last	c Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E 4 □ Pregnant at time of death 5 □ C 9 □ Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions o	ontributing to death but not resulting in the unde	erlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death? No 3 Probably 4 Unknown
			24a. Was an autopsy performed 1 Yes 2 📉	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	Hospital:		ath (Check only one)	
1 ☐ Yes 2 No	1 Inpatient 2 ER/Outpatient	- Turturoling ;	lome 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	ijury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street building, etc. (Specify)	and Number or Rural Route Number, ate)		
29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowledge, death o niner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier,		29c. License number	29d. I	Date signed (Month, Day, Year)
A. Gustin	MO	RES-COC	00	TOBER 13, 2010
30. Name and orders of person who a	completed cause of death (Item 23a) (Type, Pri	nt) EASTERN AVE	BALTI	1015ER 13, 2010 140RE 21224

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Elwood Hartman Month 2010 October 1 4:18 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Nursing Center Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday 8. Date of Birth Funeral 1 ☑ M 2 🗆 F Days Hours Min (Month, Day, Yo April 18 212-56-7553 Director 1951 Usual Residence of Decedent show 10a. State and 2 should be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Dunda1k 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2000 Paulette Road Apt. 102 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 😾 Yes 2 🗆 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates. White 1970-76 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Year Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen Cooke Elwood T. Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health sitem 27 i 21222 3146 Baybriar Road Dundalk, Maryland Alice H. Hafner (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of I
Important: If it
any injury or o
once. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns.10/16/2010 Timonium, MD f Funeral Service Licensee 21. Signatu Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 9 10 BLASTOME disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ POST-TRAVMATICSTRESS DISORDER Completed 1 Yes 2 No 3 Probably 4 Unknown TYPE 2 DIABOTES MPILITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural $5 \square$ Pending in 24 hours area control he Funeral Director: Aft Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 onth ^{Day} 2010 Year Physician/ FRANCIS D. HOLTHAUS 0.7 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8573 Main Avenue Anne Arundel Pasadena 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 XM 2 🗆 F Months Days Hours Min. Director 215 28 8181 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8573 Main Avenue 21122 U.S.A. 27 is marked other than "natural", or items traumatic event, the M-dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1952

If Yes, Give 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 K No Specify: Specify: Completed 3 - Widowed 4 - Divorced 1956 White Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Real Estate Elementary/Seconday (0-12) College (1-4 or 5+) ${\sf Self Employed}$ Investments 4 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ Emmett R. Holthaus Mary B. Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul G. Holthaus - Brother 2525 Pot Spring Rd #S.617 Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cathedral Cem 10/11/10 Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home, I 169 Riviera Dr. Pasadena, MD 21122 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EUKEMIA, CHREMC Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PROSTATIC HYPERTRUPHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an sate has I page 2 s performed Yes 2 No 2 🗌 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD 8028 RITCHIEHLY, SVISE 134, PASADONA, MD 21122

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009 29b. Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUTTNI

Please Type or Print in Black Indelible Ink. Figure All Copies Are Legible.

arryll Romeo H	nnd	State of Maryland / Departme			2010	00100				
arryn rronneo i'n			te of Death		g. No.	32106				
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	n	3. Time of Death				
edical Examir		Daryll Romeo Hood		Month October 9,	Day Year 2010	2052 hrs				
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
		Johns Hopkins Bayview Medical Center	Baltimore							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth			h (MM/DD/YYYY) 9. Birt Foreig	hplace (State or n				
Director		219 21 6005 1XM 2 F 22	Yrs. Months Days Hours Min	Apr.4		untry) MD				
		Usual Residence of Decedent				10d. Inside City Limits				
w any		10a. State 10b. County 10c. City, Town of				1 Yes 2 No				
Maryland 28a-f show d at once.	ğ	MD n/a Balt:		140	g. Citizen of What Cour	Λ				
h the Maryland 3a or 28a-f sho otified at once.	Director	10e. Street and Number 525 Chateau Ave.	10f. Zip Code 21212			itt y :				
th the 23a o				USA - 14. Race - American Indian, Black,						
th wi	Funeral	1 X Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 		White, etc.	carr indian, black,				
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Bla	ck				
rs aft ural" mine	ā	or Dates:	ecedent's Usual Occupation (Give kind of	work done	16b. Kind of Business/I					
2 hou	e e	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use ret	ired)						
thin 7 than 7 than edica	힐	1 yr.	Sales		Ford Mot	ors				
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21 Squature of Funeral Service Licensee 22 Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto Md. 21 23a. Fart I. Enter the disease, or committed in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr								
	_	23a Fart I. Enter the disease, or comflications that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	21213 Approximate Interval				
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Vital Rec ysician: The his certificate director, page	ပ	25. Was case referred to medical	26 Place of Death (Check	only one)						
of Vital Records, in Physician: The law require this certificate has been some a continued in rector, page 2 should be a control of the contr	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	tpatient 3 DOA Other Nursi		Residence 6 Other	·				
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ion trend leath tor:	atio	2 Accident Investigation	100 200 110							
Division al or Attendi rs after death al Director: A	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	m, street, factory, office building, etc.	or Town, S	Street and Number or Ru tate)					
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burner burners.		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea one) Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, and vestigation, in my opinion, death occurred	due to the caus at the time, date	e(s) and manner as stat and place, and due to th	e cause(s)				
To tl withi To tl	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d Date signed (Mo					
	=	Aust Andle 11	O.C.M.E.		October 10, 201					
		30. Name and address of person who completed cause of death (Item 23a)								
)		Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201						
St	ate	22 Pagistraria Signatura								
Regist		1 940 1 7 7 7010 7 1 1 1 1 1 1 1 1 1 1 1 1 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per FH G908 1072 Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of M	aryiand	-	rtment of F tificate of D		ia ivie	-	giene Reg. No		00107
		,	1. Decedent's Name (First, Middl	le, Last)	- 14					Date of De	ath	6010	3. Time of Death
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ING 21215-U036 filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Funeral	7070 CRADLE RO	OCK WAY, #126			21045				rog. on	ingor or virial go	USA
			11. Marital Status	12. Was Decedent 8		13. W	as Decedent of Hi	spanic Origin?	? (Specify	Yes or No-		14. Race - Amer	rican Indian,
36	after Il", or xamir	d by	1 ☐ Never Married 2 🖾 Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 🔼 Yes 2 🗌	No		☐ Yes 2 🕅 No		4011011101	311, 0101/		Black, White Specify:	
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Maryland		To B								rst, Middle,	Maiden S		
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Baltimore,	ge 1 and 2 nt of Healt it item 2 or other	13	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			ce of Disposi	ition (Name of atory or other place		Date			ocation - City or	
Ĕ	Page iment o tant: If jury or		4 Donation 5 Other (S	Specify)		TACH T		· :	/13/	2010		ROSEDAL	E, MD
ga	permit. Pag Departmen Important: any injury once.		21. Signal e of Funeral Service I	Licensee			Name and Addres						
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ω. Γ		23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each ne. Immediate Cause (Final disease or condition BLATERAL BRONCHO PNEUMONIA										Approximate Interval Between Onset and Death	
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00/9	or Attending Physician; The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	fedical		d							1		
٠ د	ending	hysician/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	y leath 3 🗆	Ectopic pregnancy	,				23d. Date of deli	very
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	rital or risaftr ral Dir			building, etc						City or Tow			
	Io the Hospital or Attending Physician; The law requires that the death certif within 24 hours after death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2 \(\subseteq Medical E	Physician: To the best of rexaminer: On the basis of ex	amination ar	nd/or investig	jation, in my opinior	n, death occurr	red at the	time, date ar	nd place,	and due to the ca	ause(s) and manner stated.
1	o the vithin o the comple	- r	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the b	pest of my kn	nowledge, de	ath occurred at the 29c, License		d place, ar			and manner as see signed (Month,	
			N.F.	la Ce				3046	9				1, 2010
	HV		30. Name and address of person of the Control of th	who completed cause of de	ath (Item 23	Ba) (Type, Pri							
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	State Registra		OCT 14	OZ. I John	s Signature	1 %	alle						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2010 0 /Medical 4c. County of Death 4a. Facility Name (not institution, give street and number 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Min Days 1 □ M 2 🗔 F Yrs Director 218-32-4828 76 08/31/1934 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "Modical Examination is ust be not the day Director 1 ☐ Yes 2 ☐ No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 WALTHER BLVD., #1514 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give 2 1 ☐ Yes 2 No \$ 3 ₩ Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 Hygiene. College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, Be and Mental LEON TERL HANNAH ROUNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is a
any Injury or other trau FRAN PERRY/SISTER 130 CAPE POINTE CIRCLE, JUPITER, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SHAAREI ZION CONGR. 10/13/2010 BALTIMORE, MD 22. Name and Address of Facility Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that chased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. | ed by the a 1 ☐Yes 2 ☐No 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 400 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 ☐ Pending investigation death. 1 Tes 2 🗆 No 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 10 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 423 00

Registrar
DHMH 17 Rev 1/2001

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31. Date

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 12, 2010 12:22 P M Mary Ruth Holtkamp Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Gilchrist Center</u> Towson 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 □ M 2 🗶 F Hours av 28, 1918 Kentucky **Director** 92 268-10-4032 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Baltimore <u>Parkton</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9 Kitzbuhel Road 21120 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 ₩ Widowed 4 □ Divorced Specify Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Disarah Branger Rebecca Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dennis Branger / nephew</u> <u>Kitzbuhel Road; Par</u>kton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Dther (Specify) 4 Donation 5 Hilltop Service Corp. 10/15/2010 Towson, Signature of Fun 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it arry, leading to him ediate cause. Enter Underlying Examine Due to (or as a consequence cry: the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 1 Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔙 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29c. License number 12 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES MA N. NOZWOT 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 01:34 PM Kampe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 706 213th Street Pasadena Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Hours 1 M 2 🔀 F June 05 1926 Country) Director 219-18-3520 84 Usual Residence of Decedent shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7856 Catherine Avenue 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 😾 No White 1 Yes 2 No Specify: If Yes, Give "natural", Completed 3 ⅓ Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Estelle Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. Mary Butterfield Pasadena, (daughter) 706 213th Street, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State t. 2010 Glen Haven Cemetery Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li en 22. Name and Address of Facility e and Address of Facility Stallings Funeral 3111 Mountain Road, Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Uremic encephalopathy disease or condition Medica! resulting in death) Due to (or as a consequence of) Examiner End Stage Renal Disease Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Dav Pregnant at time of death signed by the a Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Chronic obstructive pulmonary disease 24b. Were autopsy findings available 24a. Was an certificate has prior to completion of cause of death? page Valvular heart disease Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's residence Hospital Other: 1 Tes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No X Natural 5 Pending injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D43303 October 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Atkinson, M.D., 8028 Ritchie Hwy. #108, Pasadena, MD 21122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Duncan Kreamer October 2010 10:47AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Cente: Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
New Jersey 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 \square F Days Hours June 3. 1918 92 Months Director 156-10-1407 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore Phoenix 1 Tes 2 No 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 14 Lochwynd Court 21131 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: Completed reamer, Duncar the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) law Attorney 5+ Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances MacDermott Albert H. Kreamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Lochwynd Court Phoenix, Md. 21131 Mrs. Irma Kreamer/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Cemetery 20c. Location - City or Town, State Page 1 ; 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/12/2010 Paterson, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juner J Service Licen: 22. NaRuck Ad Tows of Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as/a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events é resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISFASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 4 No certificate 1 Yes 2 10 No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other: 은 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural Natural injury 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of the Funeral Director 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical 20a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number noma 00060687 08/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -SONY M TOMAS GIBMC. 6701 N. CHARCES ST, BACTIMORE, NO. 21204 31. Date filed (Month, Day, Year), State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 11, 2010 6:10 P M Theodore Kuehn, Jr. Albert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1931 Baltimore E. Pratt Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Hours I**llin**ois Director 83 158-16-8300 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Md N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1931 E Pratt Street 21231 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 □ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed WWII White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 <u>Engineer</u> Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Theodore Kuehn, Sr. Adelaide Bach permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mrs. Kathy Bauman/Daughter</u> 1420 Ivy Hill Road Cockeysville, Maryland 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 10/14/10 |Towson, Maryland 21. Signature of Funeral Service Lices 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** quantially list our ditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RTENSION 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 1 Yes 2 No or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home funeral 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Injury s after death.

I Director: After in by the furnishment. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 0018662 who completed cause of death (Item 23a) (Type, Print) MD21204 Mine 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Lanham Dctober 7:05p James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Towson Gilchrist Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1**X** M 2 □ F Hours 1948 Director 62 West Virginia <u>.5-54-7258</u> Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Maryland N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 410 Kingston Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Legal Paralegal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 unk permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Kingston Road, Baltimore, Maryland 21229 <u>Nancy Roane, Significant Other</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2010 Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, metastatic bladder cuncer disease or condition year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death d be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform □ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) HOSPI'CE . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident after death Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00070634 10114110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Charles

700

egistrar's Signatui

St

Baltimore

MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#20 per pHYS, G908, 10714/2010, WS

State of Maryland / Department of Health and Mental Hygiene amend #8 Per FH G908 1/2/15/10 JH Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Locke H Month Year 7:50A M Walter october 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gul Baltomore Social Security Number 8. Date of Birth 7/22/1968 Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 213-88-9641 Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State be filed within 72 hours after death with the Maryland items 23a or 28a-f shoner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimere Mary land 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 15A 12. Was Decedent Ever in U.S. Armed Forces?.

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. Never Married 2 Married ò Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: I Hygiene. other than "natural", 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Broad Wa Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Creenmont Crematory 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltomore, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 1101 E. North Are 22. Name and Address of Facility Funeral Home-Eust 21382 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Es cardion yopathe Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. that Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? Day Year Unknown 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 2 🗌 No 1 Yes Yes 24 hours after death.

e Funeral Director: After this certifical phated filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Mother's Certificate: To 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 6X Other (Sp ify**House** Natural
Accident
Suicid 27. Manmer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nskajapahre MID 00057465 10/2/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapa KSE, M.D. 2835 SmiTh AV - 5-703, Baltimore, ND. 21209 31. Date filed (Month, Day, Year) **OCT 1 4 2010** 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State of Maryla Registrar	nd / Department of Health and Certificate of Death	Mental Hygiene 2010 32195							
Physicia /Medica	1. Decedent's Name (First, Middle, Last) A Nette	Little 4b, City, Town, or Location of Death	2. Date of Death Short Pear South Pay Year 2037 M							
Examine	The Johns Hopkins Hospital	Baltimore City If Under 1 Year If Under 24 Hrs.								
Funeral Director	215-90-1481	Yrs. Months Days Hours Min.	(Month, Day, Year) Country) 9-13-1943 N.C							
ne Marylan 8a-f show tifled at	MD 10e. Street and Number	Dity, Town or Location Baltimore	10d. Inside City Limits 1 □XYes 2 □ No							
ath with the 23a or 2 ust be no		10f. Zip-Code 21231	10g. Citizen of What Country? USA							
J36 Irs after dei Ir, or Items Gaminer m	208 Douglas Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Universed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ▼No Specify:	pecify Yes or No- D Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black							
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b. Kind of Business/Industry unk							
be filed with tall Hygien and other the event, the	Pather's Name (First, Middle, Last)		me (First, Middle, Maiden Surname)							
Dattimore, Maryland bernit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event,	P Hormon Perry 19a. Informant's Name/Relationship (Type. Print) Felix J. Little-Son		e Holden ural Route Number, City or Town, State, Zip Code) Baltimore, MD 21221							
Defitimore, IM permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any injury or other tra once.	20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State 6-2010 Balto, MD							
Daltimore permit. Pages: Department of F Important: If ite any injury or of	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 1101 E. North	March East F/H Avenue Balto, MD 21202							
Physician /Medical Examiner	resulting in death) Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate Cause Cliesease or injury that initiated events resulting in death) Last b. Due to (or as a consection of the cons									
ath certific ttending p for use as	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II Other stratificant conditions contributes to death but activities.	tal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year							
v requires that the de been signed by the a should be detached	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown							
			24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No							
9 Physician: The I	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hi 28b. Time of 28c. Injury at	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	1 Natural 5 Pending (Month, Day Year)	Injury Work? 1 □ Yes 2 □ No nome, farm, street, factory, office ffy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospital within 24 hours a To the Funeral Completely filled		owledge, death occurred at the time, date and place ation and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)							
To the within To the comp	29b. Signature and the officertifier DIRECTOR, MEDICALON	29c. License number 1) 23675	29d. Date signed (Month, Day, Year)							
3	30. Name and address of person who completed cause of death (Ite Ross C. Davek ower was	em 23a) (Type, Print) 600	North Wolfe St, Baltimore, MD, 21287							
State Registra		ature								

Travis Lane
10-07775
UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 32196 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month October 9, 2010 2143 hrs Medical Examiner TRAVIS LANE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Union Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign MARY IAND
Country) Months Days Hours Min 01 Director Z 1 M 2 F 7-17-31-4239 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Iny 1 Yes 2 No BALTIMORE or items 23a or 28a-f show MD Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 21218 1539 KOAD 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Yes Specify: BLACK 1 Yes 2 No specify: If Yes, Give Year 4 Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION STUDENT 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smith SR DANIELLE TRAVIS LANE EUGENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/8 မှ 19a. Informant's Name/Relationship (Type, Print) 1539 TYNLAW ROAD Mother BALTIMORE, MARYIAND DANIELLE SMITH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 15/2010 LANSLOWNE, MARYLAND CEMETERY 4 Donation 5 Other Specify: THE DERRICK C. JOINES FIH, P.A. 21 Signature of Funeral S Con License 4611 PARK HGTS. AVE., BALTO, MARY/AND 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Nedical Death a. Gunshot Wounds (2) of Torso Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED the attending physician ned for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 Yes After th 28a. Date of Injury (Month Day, Year) Oct 9, 2010 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work Certification: Subject shot 1 Natural 2053 hrs 1 Yes 2 ✓ No 5 Pending Director: in by the 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3500 North Calvert Street, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 10, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State aire Registra

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 8:50 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Villa Assumpta Baltimore Baltimore 8. Date of Birth (Month, Pay, If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 206-14-126 Days Hours 1 M 2 F Pennsylvania **Director** T926 83 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Rant: If Ifew R27 is marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6401 N. Charles Street USA 21212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Baker Joseph A. Lebano 19a. Informant's Name/Relationship (Type, Print) Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 3215 Romilly Road; Wilmington, DE 19810 <u>Sr. Cornelia Curran</u> Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) cemetery, crematory or other place) Hilltop Service Corp. 10/14/2010 Towson, MD 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ eumonia disease or condition Medical resulting in death) e to (or as a consequence of): Examiner lars herma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 No 25. Was referred to mocal 1 Yes 2 No funeral director, 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 312, TOWSON, MD 21804 Osler Drive State Registrar

Registrar DHMH 17 Rev 7/2009

State

Box 68760

nd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 20**1**0 Melvin R. Mouring 2:57a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Be1 Harford Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 XM 2 □ F Days Hours Months Feb. 1. 1937 213-34-5748 Mary land Director 73 Usual Residence of Deceden 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🔀 No Maryland Harford Be1 Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1352 Merry Hill Court 21015 United States er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Injection Molding other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental မ William R. Mouring Helen Richter Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Alvarez, Daughter 3218 Old Forge Hill Road, Street, Maryland 21154 timore, Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/12/2010 |Baltimore, Maryland 22. Name and Address of Facilit Cremation Society of Maryalnd, . Signature of Funeral Service Licensee Amanda Heaston lesc 499 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes 2 No Yes Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

Could not be 24 hours after deal Funeral Director; Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 3 Gertifying Nurse Fractioner: To the best of my knowledge, de d at the time, date and place; and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) J D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ myers ImoThy 2010 (tunp r Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** oac Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ■ M 2 □ F Months **Director** Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Jown or Location traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 23a 21207 "natural", or items Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 1 Yes 2 If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working fife, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ther's Name (First Middle Maiden Su ပ 19a, Informant's Name/Relationship (Rural Route item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of I Important: If ite 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaughn C Greene 515 Baltimore 21. Signature of Funeral Service Licensee any National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Ph sician/ Lung (ancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No detached the Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by Division of Vital Records, 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After completed filled in by the funera 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 \square Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) Defining Physician 1 of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 10/13/10 MD. 21209

3. Time of Death

9. Birthplace (State or Foreign

3/ack

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 ☐ No

:00A

Year

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

ASRNIADOUNEM.D

N.S. Rajapakse, M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S - Rain Dallst , M - D 283 5 5 m , Th A v -

29c. License number

DO057465

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	/laryland		rtment of F		nd Mer		71111	32201		
			Registrar 1. Decedent's Name (First, Middle,	Last)		0012	incate or E	Jean	2.	Reg. No. 2. Date of Death 3. Time of Death				
	Physicia Medic		CHARC	ES E	2	Mil	LER			Cox	10 201			
	Examir	ner	4a. Facility Name (if not institution, 2328 DRUID)	give street and number)	RIVE		4b. City, Town, or BAL	Location of	Death ウRモ	•	4c. County of De	eath		
	Funeral Director		229-46-9033	6. Sex 7. A	ge (In yrs. last 73		If Under 1 Year Months Days	If Under 24 Hours		Date of Birth (Month, Day,	Year) (Birthplace (State or Foreign Country)		
	and show at	ا ا	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loca	ation					10d. Inside City Limits		
e Maryla r 28a-f s notified		Director	MARIJANS 10e. Street and Number		(3ALT	MORE 10f. Zip Code					1 Yes 2 □ No		
	n with th	Funeral	2328 DRUIN	PARK	DRI	VE		1213	5	1	0g. Citizen of What of	Country? A		
9036	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Fu	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.)	lf'	as Decedent of Hi Yes, specify Cubar	n, Mexican, F	n? (Specify Puerto Rica	Yes or No- n, etc.)	Black, Wh	nerican Indian, iite, etc. ÀACK		
21215-0036	within 72 hou giene. ier than "nat ier the Medica	Completed by	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed) College (1-4 or		(Give kii life. DO	nt's Usual Occupa nd of work done d NOT use retired)	ation during most o	of working		16b. Kind of Busines C, TY SANTA			
Maryland ?	uld be filed v Mental Hyg narked othe iatic event,	To Be	17. Father's Name (First, Middle, La	ILLER					_	st, Middle, M	aiden Surname)	7.0.0		
	2 shouth and the and the and traum	2	19a. Informant's Name/Relationshi		HER	19b. Mailing	Address (Street a	and Number o	or Rural Ro	ute Number, (City or Town, State, 2	Zip Code) 21215		
altimore,	e = t e		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 ☐ Removal from State								MORE, M.Q.		
altin	permit. Page Department Important: I any injury o	i i	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L.		ME	TROC 22.1	REMA70 Name and Addres	s of acility	116/2 The 1	PERRIC	SALTIMOR LK C. JO	E, MARYLAND NES FIH, P.A.		
8	20 E # 9	- 2	0	K C. Seco	~	- 4	OII PAR	KHG	45, A	-VE.	BALTIMON	RE, md, 21215		
بالمامام	Physician/	1 5	23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each lin	ed the death. L	Do not enter	the mode of dying	g, such as ca	irdiac or res	piratory arres	st,	Approximate Interval Between Onset and Death		
1	Medical Examiner		resulting in death)	a. Due to (or as	a consequen	ce of):		NO	7					
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury	b. Due to (or as	a consequen	ce of):								
	ate be executed ohysician and the burial-transit	al Exa	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):								
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 🔲 I	Ectopic pregnancy Other (specify)	у			23d. Date of c	elivery Day Year		
P.O.	s that the de gned by the be detached	by Ph	Part II. Other significant condition	s contributing to death I	out not resulti	ng in the unc	derlying cause give	en in Part I,		23e. Did toba	acco use contribute	to the cause of death?		
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Reco	sician: The law s certificate has t lirector, page 2 s	Completed by								autopsy perform 1 Yes 2	prior to	completion of cause of		
Vital	/sician s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ►No	Hospital:	ient 2 🗆 ER	/Outpatient	Other	r:			nce 6 🗂 Other (Spe	21		
n of	iding Phy th. After thi funeral o	cate: T	27. Manner of Death Natural 5 Pending Accident Investiga	28a. Date of inju (Month, Da	iry 28	b. Time of injury	28c. Injury work?	at	28d.	7	/ injury occurred	спу)		
Division of Vital Records,	of or Atten after dea Director: d in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determin	of be		, farm, street		103 2 110	28f. i	coation (Stre City or Town,	eet and Number or R State)	ural Route Number,		
ت	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Exa	Physician: To the best of aminer: On the basis of elurse Practioner: To the	examination an	ıd/or investia:	ation, in my opinior	 death occur 	rred at the t	me date and	place, and due to the	cause(s) and manner stated		
	To the within Comp.	4	29b. Signature and title of certifier	7	,	No	29c. License	number		29	d. Date signed (Mon	th, Day, Year)		
			30. Name and address of person when the same and address of person when the same and address of person when the same and t	no completed cause of c	leath (Item 23	a) (Type, Prin	- E	20 .	105		Jet 1	2, 2010 V 21061		
			10000	BIBO	06	93×	Avil	976	n B	1vd-	Sandel	1 21061		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	aus Signature	A	bares							

32202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 11, 2010 Ninor Jenevieve Mansius 8:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12 Old Stage Court Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30, 1933 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York Months Days Hours Min. Director 096-26-1695 77 Usual Residence of Decedent should be filed within 72 mounts and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Old Stage Court 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Vacanti

Ninor Bacanti ပ Albert Clinton Burley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Donald G. Mansius / Husband 12 Old Stage Court, Rockville, Maryland 20852 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 14 2010 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland Signature of Funeral Service Licenses 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Par 1 = ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Infarction Immediate Medical Due to (or as a consequence of) **Examiner** Arteriosclerotic Cardiovascular Disease 15 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Pregnant at time of death g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l d be det 23e. Did tobacco use contribute to the cause of death? þ Records, Seizure Disorder Completed 1 \square Yes 2 \overline{X} No 3 \square Probably 4 \square Unknown has been sig ye 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The lawn within 24 hours after death.

To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director. autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 X Yes 2 □ No Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) October 13, 2010 IDV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18perFH G908 10/19/2010 US
State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

State Registrar Peter G. Pushkas, MD

4 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

11510 Old Georgetown Road, Rockville, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ INF 43 20% Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City. Town, or Location of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Country) Age (In vrs. last birthday Funeral 1 🗆 M 2 🛛 F Days Hours Mir 04/12/1920 Director 90 Yrs. ROMANIA 212-46-5460 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral or items 23a 25 LIGHTTOWN COURT 21208 USA 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? - Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) SEAMSTRESS GARMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic YOSEF BINYAMIN STAUBER traumatic MIRIAM FRIED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANITA KNISBACHER / DAUGHTER 25 LIGHTTOWN COURT, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2010 FINKSBURG, MD BETH JACOB CONG. Signa 22. Name and Address of Facility SOL LEVINSON & BROS., INC. fun , al Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) in 24 hours after deaun. The Funeral Director: After this ce anleted filled in by the funeral dire 2 KNo Other: 1 🗌 Yes 욘 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, only one) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

		For State Registrar	Otate of W	aryland /	•	rtment of l		, ,	iene eg. No. 2 N 1 (222
Physicia Medi		1. Decedent's Name (First, Middle, Leila Morey	·					2. Date of Deat Month	Day Year	3. Time of Dea
Funeral Director		216-46-8063	PH MEDICAL 6. Sex 7. Ag	(In yrs. last to 102		-	r Location of Death OW SON If Under 24 Hrs. Hours Min.	8. Date of Birth		TIMORE thplace (State or For
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltime 10e. Street and Number	ore	10c. City, To				1	0g. Citizen of What C	10d. Inside City Lir 1 \(\sum \) Yes 2 \(\sum_{\text{y}}\)
	by F	300 Internation 11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	If	Yes, specify Cuba		ecify Yes or No-	U.S.A. 14. Race - Ame Black, Whit Specify: Wh	te, etc.
		15. Decedent (Specify only highes Elementary/Seconday (0-12) 12 17. Father's Name (First, Middle, La	College (1-4 or 5	5+)	(Give k	NOT use retired)	during most of work	ne (First, Middle, N	Own Home Jaiden Surname)	Industry
	욘	Robert Blake 19a. Informant's Name/Relationshi Barbara Morey/		I		-		ral Route Number,	City or Town, State, Zi	
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sc.) 21. Signature of Funeral Service Lie	pecify)	ceme	etery, crem top Si	ition (Name of atory or other place ervice Co Name and Addres	orp. 10/1	1	Towson, Ma	
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or a shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a bue to (or a) bue to (or as a bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) bue to (or a) b	e. ESTI a consequenc	o not enter	the mode of dyin	g, such as cardiac	or respiratory arres		Approximate Interval Betwee Onset and Dea
death certificate be executed the attending physician and ed for use as the burial-transit	9 P		D							
ificate be executed g physician and as the burial-transit	Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. CORO	a consequence	ce of): / /A ce of):	RTERY	/ DISE	ASE		
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w requires that the death certificate be is been signed by the attending physic 2 should be detached for use as the b	Medical Certificate: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d. Due to (or	of pregnancy 2 Fetal de at time of death but not resulting the resulting of the resulting o	ceath 3 ceath 5 ceath	Ectopic pregnand Other (specify) derlying cause give 26. Pl 3 □ DOA 28c. Injun work M 1 □ et, factory, office coursed at the time pation, in my opinic anth occurred at the	ven in Part I. ace of Death (Checer: 4 Nursing H y at (? Yes 2 No	23e. Did tob 1 Yes 24a. Was ar autops perform 1 Yes 2 2k only one) ome 5 Reside 28d. Describe how 28f. Location (Str. City or Town, and due to the caus at the time, date and ce, and due to the caus	23d. Date of de Month acco use contribute to s 2 No 3 F P P P P P P P P P P P P P P P P P P	Day Year Paral Route Number, Day Year Day
To the Hospital or Attending Physician: The law requires that the death certificate be executed within Z burs after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as a d. Due to (or	of pregnancy 2 Fetal de at time of death but not resultin tient 2 ER/ iny y, Year) The property of the prope	ce of): Country Country	Ectopic pregnanc Other (specify) derlying cause give 26. Pl 3 DOA Other 28c. Injury work of the specify of the specific pregnance of the specific pregnance give 29c. License 29c. License 24 4 4	ven in Part I. lace of Death (Checer: 4 \(\text{Nursing H} \) y at ?? Yes 2 \(\text{No} \) n, death occurred a e time, date and place a number 5 7 5 3	23e. Did tob 1 Yes 24a. Was ar autops perforn 1 Yes 2 25k only one) 28d. Describe how 28f. Location (Str. City or Town, and due to the cause the time, date and ce, and due to the c	23d. Date of de Month acco use contribute to s 2 No 3 F P P P P P P P P P P P P P P P P P P	Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 8:05 2010 Рм Marshall Leora Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 21, 1909 1 🗆 M 2 🛛 F Months Texas **Director** 101 410-76-9375 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shomust be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Towson 1 🗌 Yes 2 🛛 No Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21204 407 Woodbine Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Dewar Charles Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Woodbine Ave. Towson, Md. 21204 Mr. Bill Marshall 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plac Woodlawn Cemetery 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XOther (Specify) tombment Nashville, TN. 10-18-10 21. Signature of Furreral Service Licensee 22. Name and Address of Farllowson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Renal tuilve Medical Due to (or as a consequence of): **Examiner** euwent Securations for conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Dementio Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 VN 1 Tes 2 🗌 No To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 A Other (Specify) Hospic C 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within Z 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

N

Pate 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#15 per FH, G908, 10/20/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical TIBLE Roset Nelson 4a. Facility Name (if not institution, give street and number)

Makuland Grenzral Ho 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ortal etimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Sate of Birth 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔏 F Days Hours Min (Month, Day, Year) Director Yrs. 9-27-1959 216-76-4667 MD 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD na Baltimore 1X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10q. Citizen of What Country? Funeral 21202 1721 Lamont Avenue U S 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 0 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10th grade^{Unk} Various Jobs College (1-4 or 5+) Laborered Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie James Nelson Shirley Mae Jordan 19a. Informant's Name/Relationship (Type, PrintBrother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman Lonnie Nelson-3332 Cliftmont Avenue Balto,MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion Cemetery 10-12- 10 20a. Method of Disposition 20c Location - City or Town, State ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lansdown, MD 21. Signature of F in al Service Lin 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy rmed? death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 12 Natural injury 5 Pending 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cartifying Nurse Exactioner: To this but of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 10/2/20/030. Name and address of person who completed cause of death (Item 23a) (Type, Print) rasoud Meh RIZI M.D. 40 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Fredricka Ann Nicolosi Oct 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death S 8034 Gray Haven Road Dunda1k Baltimore Co. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 12010 **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours May 29, 1945 1 M 2 X F 212-44-3369 Maryland Director 65 Usual Residence of Decedent 10/08/ items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8034 Gray Haven Road 21222 United States 1501021 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical? 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Janitor Public Schools Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Arkins Louise Zulauf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1613 Oak Park Lane Helena, AL 35080 Josephine A. Tofani (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp. 10/14/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Buda-Racks Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiovascular Disease Onset and Death Physician/ disease or condition resulting in death) +erioscler Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

10:54P M

1 ☐ Yes 2 🖾 No

Year

State Registrar (Check

only one)

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

Trimble

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Hill CT. Latherville, Md

			For State Registrar		State of	Marylan		artmen <i>tificate</i>			and M	lental Hy	giene	20	10	322	0.8
	Physicia Medi		1. Decedent's Name	e (First, Middle,	Last)			·	Noue	t		Month	. Date of Death		Year 2010	3. Time of 04:1	Death
	Exami	ner		OSEPH	give street and numbe MEDICAL 5. Sex 7.	•		4b. City, Town, or Location of Death Towson If Under 1 Year If Under 24 Hrs. 8 Date				8. Date of Bir	4c. County of Dea				
	Director		579-30-2956 Usual Residence of	5	1 □ M 2 💢 F	83	Yrs.	Months	Days	Hours	Min.	11/09/1			Count		
	: Maryland 28a-f sho notified at	irector	10a. State	10b. County		10c. City Balti	r, Town or Lo	cation							1	0d. Inside Cit	,
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may njury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	10e. Street and Nun					10f. Zip	8					g. Citizen of What Country?				
	urs after dea tural", or iter al Examiner	ted by Fu	11. Marital Status 1 Never Marri 3 Widowed	4 Divorced	If Yes, Give Year or Dates	s? 🕱 No	İ	Vas Decede f Yes, speci	fy Cubar	n, Mexican,	jin? (Spe , Puerto I	cify Yes or No- Rican, etc.)			e - America ck, White, e		
	within 72 ho giene. ier than "nat r, the Medica	Completed	(Spe Elementary/Seco 12		's Education t grade completed) College (1-4 c	or 5+)	life. Do	ent's Usua kind of work DNOT use 12 Make	retired)	tion uring most	of workii	ng	16b. К Оwn Н		usiness Ind	lustry	
	ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (f	First, Middle, La	st)		Ahe	ern		18. Mothe Rose	r's Name	(First, Middle,	Maiden (Sumame	^{e)} U	nknown	
	and 2 shou Health and Im 27 is m		19a. Informant's Na	Nouet, S			1302	Northy	iew R			Route Numbe			State, Zip C	ode)	
	Page nent c ant: If		4 Donation	☐ Cremation 3 5 ☐ Other (Sp		ate ce	ace of Dispo emetery, crem uid Rido	natory or ot	e of her place		0/14,	/2010	Balt	timor	e, Mar		
Balti permit. Departr Imports any inju				mining	- 71	ب ا	5		rforc	Road,	, Bali	onard J. timore, M	1D 212		•		
09	death certificate be executed Medium	dical Examiner	snock, or near immediate Cause (I disease or condition resulting in death) Sequentially list continue to the cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	nditions, mying injury	b. LLR Due to (or a	ine. PS 2 as a conseque NAR as a conseque as a conseque	y T/	RACT	J	NF	FCT	ION				Interval Betw Onset and D	
Box 687	death certific ne attending ed for use as	₩	IF FEMALE: 23b. Was decedent in the past 12m 1 Yes 2 9	pregnant conths? No	23c. If yes, outcom 1 Live Birtl 4 Pregnan 9 Unknow	h 2 ☐ Fetal t at time of de	death 3	Ectopic pr Other (spe	egnancy					23d. Dat Moi	te of delive		ear
s, P.O.	ires that th signed by Id be detac		_		s contributing to death		_	, ,	ause give	en in Part I.		23e. Did to			_	e cause of de	
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Division of Vital Records,	The Hospital or Attending Physician: The law requires that the within 24 hours after death. In the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate: To Be	25. Was case referre examiner? 1 Yes 2 2 27. Manner of Death 1 Natural 2 Accident	No 5 Pending Investiga	28a. Date of in (Month, E	atient 2 Enjury 20ay, Year)	R/Outpatient 28b. Time of injury		Other c. Injury a work?	4 ∐ Nur	sing Hor	only one) ne 5 □ Resid 8d. Describe h					
Divisi	Hospital or Atten 24 hours after deat Funeral Director: sted filled in by the		3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	ed 28e. Place of II building, e	etc. (Specify)						8f. Location (S City or Tow	n, State)				er;
	To the Hospital within 24 hours To the Funeral completed filled	Medical	29a. Certifier 1 (Check 2 only one) 3 29b. Signature and t	☐ Medical Exa ☐ Certifying N	hysiciam To the best of miner: On the basis of urse ractioner: To the	examination :	and/or investi	gation, in m	v opinion	, death occ time, date a	urred at t	he time, date and and due to the	nd place, e cause(s)	and due and ma	to the caus	se(s) and man ted.	ner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year OUISA ICHAN 101 09 P Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTMORE ๆ MARYLAND MEDICAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TyF Days Min. Hours 212-21-6839 NOV. Day 9ear 1965 Director 44 CAMEROON Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits MD MONTGOMERY BURTONSVILLE 1 X Yes 2 No items 23a or 10e Street and Number 10f. Zip Code the Medical Examiner must be 10g. Citizen of What Country? Funeral CABIN CREEK DRIVE Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. ŏ ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ☐ Yes 2 Tx No If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Completed Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) YRS NURSE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN E. SONA MAGDALENE SATIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau WILLIAM ADAMU/BROTHER IN-LAW 2901 CABIN CREEK DRIVE BURTONSVILLE, MARYLAND 20866 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State GATE OF HEAVEN 10/16/2010 SILVER SPRING, MD 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician MPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or ii that initiated events -tran Due to (or as a consequence of): resulting in death) Last igned by the attending physician a be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Completed METABOUL AUDOSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate 2 No 1 Yes 2 No Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 \square Pending injury 1 ☐ Yes 2 ☐ No Investigation filled in by the Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 29a. Certifier within 24 hor

To the Fune

completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

3

31. Date filed (Month, Day, Year)

re and title of certif

only one)

ARUL

29b. Sign

MP

MMMC

32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

GLEENE ST

1104085448

BAUTIMORE

A44176435 T19005

29d. Date signed (Month, Day, Year)

30

2010

Baltimore, Maryland 21215-0036

Box 68760, signed by the a Division of Vital Records, P.O.

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 45 AM MEM 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEran Quail (a) KENT roint MES 9. Birthplace (State or Foreign Country)
Australia Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 1**X**M 2□ F Months Days Hours 218-38-4570 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Medical Evaluation to motified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2□No Funeral Director rr\d Ertown 10e. Street and Number 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify. <u>ک</u> White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor Johns Hopkins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Keith Phillips Madeline Constance Lofts 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merle W. Phillips, Wife 462 Quail Ct. @ Heron Point Chestertown, MD 21620 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Metro Crematory Inc. 10/14/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or commications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ADENOCARCINOMA **Physician** GASTRIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusity for as a consumence of Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ EMBOLIC STROKES Completed 24a. Was an autopsy performe 2 No 1 □Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Tes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No reral Director: / investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO041587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 5 122 SDEER HELEN 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> months 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chestertown Md. 21620 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g908 10-14-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08 Day 10 Month Physician/ 2010 MARLENE C. PARKER 1:21 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worchester ⁵2Spcial Security Number 218 78 8962 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country)
 MD 1 □ M 2 🔀 F Months Days Hours Min. 7^{(Month} 2^{Day} 1^{Year} 39 Director 71 MD Usual Residence of Decedent other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Worchester Ocean City 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 Coastal Hwy Apt 6-228 21842 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Merril Lvnch permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter L. Ballard Rose M. Marney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 19a. Informant's Name/Relationship (Type, Print) Patrick Parker - Husband 3701 Coastal Hwy Apt 6-228 Ocean City, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Cem 10 12 10 Glen Burnie, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, I 23a. Part *. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in racially cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine Due to (present Due to (or as a con-IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 2 No 3 Probably 4 Unknown Be Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} မ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ctated. (Check only one nd title of certifier 29d. Date signed (Month, Day, Year) 00063904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Drive Balin MD 218/1 John Gillespie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32212 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Philip H. Philbin 2010 10. October 17:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Sept. 23, Massachusetts 88 ^{Year}1922 Director 015-18-7528 Yrs Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location
Vero Beach Director 10d. Inside City Limits Florida Indian River Yes 2 No Bethesda 10e. Street and Number 10f, Zip Code **32963** 2081 7 1440 Ocean Drive #15 10g. Citizen of What Country? Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1949 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1956 3 Divorced Specify: White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Surgeon Surgery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Philip M. Philbin Ruth Mower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine T. Philbin/Wife 6724 Michaels Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20c. Location - City or Town, State 1 Burial 2 Decremation 3 Removal from State October 12, 4 ☐ Donation 5 ☐ Other (Specify) Prium, Inc. 2010 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee Bethesda, Maryland M01596 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dementia Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 2 No Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 2 🗆 No 1 Tes vision of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37891 October 11, 2010 25* 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 Congressional Lane, #409, Rockville, Maryland Rajvanshi, M.D. 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland Department of Health and Mental Hygiene per me, g908, 10/14/2010dhb Certificate of Death 32213 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 25, 2010 Physician/ Francis Person, Jr. 2357 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville montgomery Social Security Number 8. Date of Birth July 27, 1921 If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 523-18-7345 89 Yrs Colorado Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c, City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 Medical Center Drive, #223 20850 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 19481 2 Yes 2 No
If Yes, Give
Year or Dates. 1952 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chemical Marketing and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Callege (1-4 or 5+) and Consulting Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Person Louise Schaer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Francis S. Person / Son 7351 Freestate Drive, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State September Montgomery Crematorium, Inc 30, 2010 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 lette L M01305 Part 1/ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ Left below knee stump wound steks disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events EXAMINER Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran CERTIFICATION APP Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD exacer bation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown medication toxicity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 № Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and time of certifier D 20148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1511 Steven Russell Ave. Gaithersburg, Dolinsky 911 MD State Registrar

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Division of Vital Records, P.O. Box 68760

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Physici Vledical Exam			2. Date of De Month	Day Year 0153 her						
)		Marcus Callaway Rapter, III	October or Location of Death	4c. County of Death						
		6905 Crain Highway La Plata		Charles						
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Months Da	un House Min	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Kansas						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim	nits						
*	or	MN Nicollet Saint	Peter	1 Yes 2 XI	No					
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?						
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eath w items	Funeral	1 Never Married 2 Married 1 Yes 2 X No	ispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
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5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup- during most of working life		16b. Kind of Business/Industry						
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21215-0036 vald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Marcus Callaway Rapier, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	D. Lucill							
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2 a a a a		20a. Method of Disposition 20b. Place of Disposition (Name of co		20c. Location - City or Town, State						
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory,	Inc. 10/13/10	BAltimore, MD						
Salti ermit. Pepartm mports njury c		21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address	ss of Facility Cremation	Society of MD, Inc.	_					
Physician	-	299 Fred 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	derick Road BAl	timore, MD 21228 rest, shock, or heart Approximate Interv	val					
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Peritonitis	,,	Between Onset an Death						
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Box 6876(e death certificate the attending phy ed for use as the b	iciar	past 12 months? 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	Month Day Year						
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should	Be Co	25. Was case referred to medical 26. Place	e of Death (Check only one)	2 No 1 Yes 2 No	_					
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isior Attencer death rector:	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office		Street and Number or Rural Route Number, Cit	tv					
Division Hospital or Attence 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S		,					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C	29a. Certifier								
£ 3 £ 3	Me	29b. Signature and title of certifier 29c. Licens	se number	29d. Date signed (Month, Day, Year)	_					
		0.c.	M.E.	October 12, 2010						
			, Baltimore, MD 21201							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 22^{Day} 2010 12:00 M A. Roberts Gladys Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner na McElderry Street Baltimore 2501 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 2-7-1946 7. Age (In yrs. last birthday) Funeral 1 □ M 2 F 64 215-46-5277 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland by Funeral Director 1 X Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21205 2501 McElderry Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes Domestic 6th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louvinia Allen Sidney Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
745 Springfield Avenue Balto, MD 21212 19a. Informant's Name/Relationship (Type, Print) Veronica Roberts-Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 10-4-2010 Baltimore, MD Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Cause (Disease or iinjury that initiated events or Attending Physician; The law requires that the death certificate be executed resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury Accident 2 No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 D62589 and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 1000 E Eager St mD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Edward Rapski 201 $:40p^{M}$ October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore If Unde 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth **Funeral** If Under 24 Hrs. 1 XM 2 - F Months Days Hours Jan. 20 Yer 932 200-24-3457 78 Director Usual Residence of Decedent 28a-f shov 10a. State with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Dundalk MD Baltimore 1 Yes 2XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Mavista Avenue United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married and 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Completed 3 Divorced 4 Divorced 1952-54 Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working other than life. DO NOT use retired) filed within Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Years Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည be Sophie Giblak permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic ence. Josef Rapski Maryla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland Mrs. Mary A. Rapski (Wife) 1 Mavista Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns.10/16/2010 Middle River, MD 4 □ Donation 5 ₽ Other (Specify) Entombment Signature of Funeral Service Licensee 22. Name and Address of Facility al Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pulnowary Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner UNENOUN Lung Cancer Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician are the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autonsv death? certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) 2 X No 1 Yes Other: မ 1 Inpatient 2X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MD/PLD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**McLae Williams 6701 W. C

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Bay, Year)

N. Charles ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per Phy G908 10/25/10 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 3. Time of Death Physician/ Ricklin, Sr. Clifton William Oct. 1010 9:10 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maples of Towson Assisted Living Baltimore Towson Social Security Numbe 8. Date of Birth
(Month, Day, Yea
Feb. 2, 1 6. Sex 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. 1 🔀 M 2 🗆 84 219-16-9680 Yrs. Director 1926 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk 1 Tes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1952 Frames Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3X☐ Widowed 4 ☐ Divorced Year or Dates. WWII Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Refrigeration Mechanic Refrigeration 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Dunnavant Charles Ricklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Delma Ave. Pasadena, MD 21122 Mrs. Mary Buzgierski (Daughter) Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 $\stackrel{\mbox{\scriptsize M}}{\mbox{\scriptsize E}}$ Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 10/16/2010 Baltimore, Maryland 4 ☐ Donatign 5 ☐ Other (Specify) Signature of Funeral Service Licenses ²²Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart aligned this only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysiciani disease or condition Medical resulting in death) Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No page After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury a 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation Director: / 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier rifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Numa Practioner: To the best of my knowledge at the time, date and plans, and due to the 29b. Signature nd title of certifier 29c. License number IN 2010 36. Name and address of person who complete cause of death (Item 23a) (Type, Print) CHARLES and 81. Date filed (Month, Day, Year, 32. Red State 2120 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5 8perFH G908 10/15/2010 WS State of Maryland Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M9nt) 2141M RUAN 2010 Kay 6 OHN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George' Hospice of the Chesapeake Harwood 8. Date of Birth 1963 7. Age (In yrs. last birthday) 47 yrs If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Funeral ZM2 F Months Director MD Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Powhatan VA Powhatan 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23139 USA 6341 Walnut Tree Drive 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2XXNo Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Bruce Ryan Beverly Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 2938 Rogers Avenue, Ellicott City, MD Leslie Marie Ryan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 10/09/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Foreral Service Licensee Dorota Marshall Mais 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ A WINEZ METAGNANC LUNG Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Stone BANDR (W 2 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) HOSPEE 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOUS MO21401 m 445 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

BCT 14 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cassie Mae Runge 4:30 A.M 2010 October 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Genesis Eldercare Hammonds Lane Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🏝 I Months Hours ^CFTorida 98 265 10 9822 01/30/1912 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 305 East Joppa Road Apt. 2108 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Self Employed Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Cobb Maybelle Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel McComas / Niece 5206 - 4th Street Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 10/12/2010 | Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 reminer 23a. Jert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician neumbula disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of confifier 29c. License number 230555 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21270 Exit Fat Avenue

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 32220 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **JESSICA** SUE REVELS Month Day October 6, 2010 Medical Examiner 0549 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital **Baltimore County** Rosedale 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Months Days Director 212-60-8582 1 M 2X F 55 10-20-1954 Country) N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE MIDDLE RIVER 1 Yes 2 XNo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trannatic event, the Medical Examiner must be notified at oncr. Director 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 2 CONTROLL COURT 21220 U.S.A. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White etc 1 X Never Married 2 Married 2X No Yes Specify: WHITE If Yes, Give Year 1 Yes 2X No specify: 4 Divorced ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) d other than ", HAIRDRESSER SALON 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JESSE REVELS, LUCY JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY REVELS, SR./BROTHER 5016 CHADWICK CT SPRING GROVE, PA 17362 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State HOLLY HILL MEMORIAL 10-11-10 MIDDLE RIVER, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fundervi e Licensee 1211 CHESACO AVE ROSEDALE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Narcotic (morphine) intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and hysician/Medical ttending physician a r use as the burial -X UNPENDED AMENDED 23a, PII, 27, 28a-f, per ME g908 10/21/10 TT The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Ď 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed Division of Vital Records, has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed^a 1 Yes 2 No Yes 2 ✔ No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 No Director: Pending Fd 10/5/10 Fd 1300 hrb 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 COntrol Court Middle River, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be Middle River, residence determined 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 7, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g908 10-14-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCTOBER 7:40 PM Doris M. Ralph Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOODSAMARITAN HOSPITAL BALTIMORE 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 ☐ M 2 🛣 F 219-28-7974 Months Month, Day, Days 1932 Hours Min. Director 78 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location
Baltimore be notified at Director 10d. Inside City Limits MD N/A 28a-f 1 X Yes 2 ☐ No 10e. Street and Number 'n 10f. Zip Code 10q. Citizen of What Country? Funeral 4917 Herring Run Dr. 21214 USA ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Clerk Typist Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Hamlett Lura Betts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Bernard Ralph?Husband 4917 Herring Run Dr. Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arbutus Mem Pk. 4 ☐ Donation 5 ☐ Other (Specify) 10/14/10 Arbutus, MD f Funeral Service Licenses 22. Name and Address of Facility Betts Funeral Home 1129 N. Caroline St. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIORESPIRATORY disease or condition Medical resulting in death) Examiner ENCEPHAL HYPOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events tran and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month signed by the a Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 X No certificate 25. Was case referred to medical director, B 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🔀 No Other: 2| 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 24 hours after death le Funeral Director; A ☐ Accident☐ Suicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DOO 68987 M. D. 10/08/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCHRAVEN SHAMS T. QUAZI

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Bay, Year) -

32. Rotrar's Signature

BALTIMORE

21239

32222

			1 - State Registrar		rtificate of Death	,,	ene g. No.						
	Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death					
	/Medi	cal	Dorothy	Sco		10 2010	3:45 p _M						
	Examir	ner	4a. Facility Name (If not institution, give street and number) Genesis Homewood		4b. City, Town, or Location of Deat	h	4c. County of Death						
	Funeral			s. last birthday)	Baltimore Hunder 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day,	na a Birtho	lace (State or Foreign					
	Director		217-38-7414 1 M X F 68 Usual Residence of Decedent	Year) Coun	MD								
	aryland show	_		City, Town or Loc	eation		1	0d. Inside City Limits					
	he Ma	ecto		Baltime	ore			1X Yes 2 □ No					
	with t	Ö	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	try?					
	ns 23	Funeral Director	1115 Brentwood Avenue 11. Marital Status 12. Was Decedent Ever in U	19 12 V	21202	Inneit Van er N-	USA						
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apply injury or other traumatic event, tra Preficul Evanter, cust be rutified at once.	Completed by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, 3 Widowed 4 Divorced Armed Forces? 1 Yes, 3 No If Yes, 3 No If Yes, 3 No Year or Dates:	If	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	to Rican, etc.)	14. Race - Americ Black, White, e Specify:	an Indian, itc. ack					
2-0	72 hc 'natu	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation	rking 16	6b. Kind of Business/Inc	lustry					
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Q Q	filed Hygi other	ပိ	10th grade 17. Father's Name (First, Middle, Last)	HOI	usekeeping	ne (First, Middle, Ma	Hotels						
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ary	should I and Men s marker	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street and Number or Ru			Code)					
, Z	1 and 2 Health a em 27 is		Dorothy Smith-Daughter		Clearspring R	_	Lto, MD 2						
altimore, Maryland	Pages 1 ment of Ha ant; If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Place of Dispos cemetery, crem t Zion	ition (Name of atory or other place) Cemetery 10-	Date 20 15-2010	Lansdown						
Balt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee		Name and Address of Facility L101 E. North		Cast F/H Balto, MI	21202					
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1	/Medical Examiner		Due to (or as a consecution)	quence of):									
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õ	ertific ling pl e as t	Med	IF FEMALE:					12					
X P	death certificate be executed e attending physician and d for use as the burial-transit	sician/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death 3	Ectopic pregnancy		23d. Date of delivery						
	the de	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of 9 ☐ Unknown 9 ☐ Unknown	death 5 □	Other (specify)		Month	Day Year					
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5	Physician: r this certificaral director, p	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐		3 DOA Other: 4 Nursing H	ome 5 Residenc	e 6 ☐ Other (Specify))					
ָב ב	ding l h. After funer	io	27. Man ≠ of Death 1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred						
DIVISION	Atten deatl ctor: y the	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury At h	ome farm etree	M 1 Yes 2 No	006 1							
5	urs after urs after ral Dire	Certification:	4 Homicide determined 28e. Place of Injury - At h. building, etc. (Special			City or Town, S	,						
	or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knd one) Certifying Physician: To the best of my knd one of the best of the best of my knd one of the best of the be	wledge, death of ation and/or inve	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as sta and place, and due to	ited. the cause(s)					
i	o vit	2	29b. Signature and title of certifier		29c. License number		Date signed (Month, D						
			4		D0070076	10	0/11/2010)					
	2		30. Name and address of person who completed cause of death (Item Ramana kankanala, 8813)	n 23a) (Type, Pr	int)	Day Pa	. Knilla nah	1112					
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signa	iture /	un whoos for 34	e 4001, 100	WILL IND	1-21254					
	Registra		OCT 142010 Russ D.	MANKE									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 10 Physician/ Month Day 9 COTT Z:30 PM Medical Facility Name (if ot institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Min. (Month, Day, Year) Country) Director Yrs 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 ☐ No MD timore 10f. Zip Code 10g, Citizen of What Country? Funeral Helock Acenu . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) nani Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) chester Ave, Method of Disposition 0b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 40 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Severe Pulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Interstitia Luna Sequentially list conditions, Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Pulmonary that the death certificate be executed Obstructive Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown ed by t detach signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Records. 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available Heroin autopsy performed? Yes 2 X No prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Sarcoidosis Hospital or Attending Physician: The Vita 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending work?
1 Yes 2 No death. Accident Investigation after death 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certific D50770 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1000 E. Eager St. MD Baltmore a 0 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 32224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTO DEN heila 7:57 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 220-64-289 Country) Director Yrs. Usual Residence of Dece show 10a. State 10b, County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 □ No timore 10e. Street and Number ō 10g, Citizen of What Country? Funeral items 23a 21211 11. Marital Status 12. Was Decedent Ever jp U.S 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea any injury or other traumatic event, the Meaonee. College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ည nclean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smith Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State gemetery, crematory or other 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent eene Funeral Istin MDH133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ gastrointestinal bleeding disease or condition resulting in death) Medical Examiner eticlogy undetermine Sequentially list conditions Examine Due to (or as Insequence of) if any, leading to immediate cause. Enter Underlying Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Be Completed by Physician/Medical Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown should be detached 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of Death To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pragitioner. To the best of my knowledge, death unsumed at the time, date and place, and due to the 29b. Signature 29c. License number MD Res 000 October 72010

Registrar

State

Singi

Hospital of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YUMUL MD

Ily Kristine T.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#28b, 28f, perME, G909, II/10 / 2010, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NHOL SINGER 1657 HOWARD 10 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER Security Number Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours May 28, Year) Min. Mary Land Director 220-21-8840 28 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore County Baltimore 1 Tes 2 X No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filled within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other any injury or other. Funeral United States 21206 5630 North Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: If Yes, Give 3 - Widowed 4 - Divorced White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Moving Service Technician 9 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna King Michael Singer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5630 North Lane Baltimore, Maryland 21206 (Mother) Anna Singer 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2010 Baltimore, Maryland Gardens of Faith Cemi 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Wise Dundalk, Maryland Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 Hours Immediate Cause (Final Physician/ TRAUMATIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SPIRATORY HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of HEATION Cause (Disease or linjury that initiated events Hours resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SKULL FRACTURES, BILATERAL SUBDURAL AND SUBARACHNOID 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HEMORRHAGES, CEREBRAL EDEMA, OCCIPITAL CONDYLE PRACTURE. autopsy performe BILATERAL PETRUS TEMPORAL FRACTURES, LEFT BUNE 1 ☐ Yes 2 No Yes 25. Was case referred to medical examiner? Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 905 m Natural
Accident 5 Pendina 1 ☐ Yes 2 🛣 No CRASH SCOOTER Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number of Bural Route Number of Bural Route Number of Bural Route Number of Bural Route Number of Bural Route Number of Bural Route Number of Bural Route Number of Rosedale, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and out to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100542 10/12/10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC D. MARTIN UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE, MD State 31. Date filed (Month, Day, Year) 32. Regi 1 4 2010 OCT Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32226 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 Judith C. Schugar 10:36 P^{M} Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b City Town or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 🛛 F Months Hours January 2 Director 383-36-9767 Michigan 70 1940 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 ☐ Yes 2 X No Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Oldham Road 20901 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 □ Divorced Specify. White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank L. Walsh May Bell Pryce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis W. Schugar / Son 10004 Connecticut Avenue, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 13 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc 2010 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ₽nysician/ disease or condition resulting in death) Cardiac Arrest Minutes Medical Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, cause. (Disease or iinjury Due to (or as a consequence or) law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Pregnant at time of death Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 X No Hospital or Attending Physician: The l 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ျ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei To the Hosp within 24 ho To the Fune completed fi (Check 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) talle MD D0063136 October 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Richard Thomas Mahon,

MD

32. Registraris Signature

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8901 Rockville Pike, Bethesda, Maryland 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh g908 10-14-10 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Dennis Tapley, Sr. October 1:30 P. M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford County Hart Heritage of Forest Hill Forest Hill 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Nov. 23 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F 80 78 Yrs. 262-36-5300 Director Georgia Ĩ 931 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d, Inside City Limits Director Florida Polk County Winter Haven 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 96 Lameraux Road 33844 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Florida Power Meter Reader 12 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cordie Tapley Bertie Lou Meeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 4458 Graceton Road, Pylesville, Maryland 21132 Thomas Tapley, Jr. (Son) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🗎 Cremation 3 🔀 Removal from State 10/16/10 Winter Haven, Florida Rolling Hills Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 -car A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demantis STASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Uncernying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 🗌 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 No 2 🗆 No 1 Yes ASSIS ted 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifies 39889 DC+01321 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIS W. MACPHAIL RD BELAIN, MAD 201 ALFRED

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roger October 9^{ay} 2010^{ar} 7:30P M Thornton, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/AExaminer Sloatfield Avenue Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 □ F Days Ap Month, 27, Year 937 Hours Min. 239-54-0241 73 NofthyCarolina **Director** Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDN/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2615 Sloatfield 21223 United States <u>Avenue</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Warehouseman Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luby Thornton Annie Westbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Thornton / Wife Sloatfield Ave., Baltimore, MD. 21223 Carolyn Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 10-15-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilitAMBROSE FUNERAL HOME, INC. au 1328 Sulphur Spring Rd., Arbutus, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ COLORECTAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence cry Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ THEOMBOSIS VENOUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be

Box 68760 P.O. Records, of Vital Hospital or Attending Physician: nours after death.

neral Director. After this iffiled in by the funeral di Division 24 hours npleted f To the I within 2 To the I complei

Registrar DHMH 17 Rev 7/2009

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29a. Certifier

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determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

rted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number,

OCTOBER 14,2010

City or Town, State)

-PL. BALTIMORE MO 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 9 2010 Allen C. Testerman 5:45 P M Medical 4a. Facilify Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lansdowne Baltimore 3416 Bero Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F 83 Months Days Hours Min. Jan. 21, Year 927 Virginia 229-24-9085 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director MD Baltimore Lansdowne 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f Zip Code 9 10g. Citizen of What Country? Funeral 3416 Bero Road 21227 United States permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. ģ 1 Never Married 2X Married Saltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
Unknown College (1-4 or 5+) Machine Operator Kaiser Aluminum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Polly E. Unknown Albert Testerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3416\ Bero\ Road$, Lansdowne, MD 2122719a. Informant's Name/Relationship (Type, Print) Terry Testerman - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 10-14-2010 Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final REMAL ACUTE Physician/ disease or condition resulting in death) week Medical Due to (or as a consequence of) Examiner FRONIC RENAL FAILURE YPERTENSION Cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury D mouths CONVIESTIVE HEAFT that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Vear Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA - ALZ HEIMERS. Division of Vital Records, 1 Yes 2 No 3 Probably 4 🗓 Unknown PERIPHERAL VASOULAR DISPASE 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 X No Yes Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

D0038041

4W. ROLLING CROSSROADS, CATONSVILLE MD 21228

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tara Taylor		- For State Registrar	Stat	e of Maryla			rtment of <i>tificate of</i>			Mental F		Reg. No.		10	322	31
Physician Medical Examine	4	1. Decedent's Name (First TAI		ast)	-	TAYI	LOR				2. Date of De Month October 2	Day	Year		3. Time of Death 0302 hrs	
	ľ	4a. Facility Name (if not in Atlantic General			mber)		•	4b. City, T Berlin	own, or Lo	cation of Deat	h		. County of Vorcest e			
Funeral Director		5. Social Security Number	1	Sex M 2 F	7. Age (In	yrs, las	st birthday) Yrs	Months		If Under 24Hr Hours Min	s. 8. Date of B			9. Birth Foreign Cou	place (State or WASHINGT htry) DC	
any	_	Usual Residence of Deced 10a. State 10b. C			100	. City, 7	Town or Locati	on				_			10d. Inside City L	imits
faryland 28a-f show any Lat once.	5 -	MD PR	INCE	GEORGE'S		L	ANHAM	10f, Zip	2.1			10. 011	izen of Wha		1 X Yes 2	No
the Maryland a or 28a-f sh tifted at one	5	6704 TERRA	АТ.ТА	DRIVE					706			USA		n Couri	y:	
er death with t	<u> </u>	11. Marital Status 1 Never Married 2		12. Was Dec	orces?	r in U.S		s Deceder	nt of Hispa	nic Origin? (S lexican, Puert	pecify Yes or No Rican, etc.)				an Indian, Black,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Elineral Director	2	3 Widowed 4 Divorced If Yes, Give Year or Dates:				2 No No 1 Yes 2 No specify:						Specify: BI				
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, I MARVIN	Middle, La BASKE						18.		e (First, Middle, A TAYLO		Surname)			
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e, MD I and 2 sho Health and item 27 is		VANESSA TA	า				ace of Disposematory or oth	ition (Nam			Date		Location - C			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Buria! 2 Cre 4 Donation 5 Ot	her Speci	fy:	om State		VERDALI	E CRE			11-2010	R	IVERDA	ALE,	MARYLANI)
Balt permit Depart Impor injury	4	Signature of Funeral S	Service Lic	ensee			- 1		Address of	J.					HOME, IND 20785	
Physician	1	23a. Part I. Enter the disea failure. List only one		each line. Dr	ownin	ig c	omplic	e mode o	dying suc	ch as cardiac	or respiratory ar	rest, sho	ock, or hear		Approximate Inte Between Onset	erval
Examiner		Immediate Cause (Final door condition resulting in de		a. Phe Due to (or as a			ine In	toxic	atio	ם				\dashv	Death	
<u> </u>		Sequentially list conditions if any, leading to immedia	le	b. Due to (or as a	consaqua	nes of):										—
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60, ate be ex obysician he burial		W UNPENDED F FEMALE:		23c. If yes, o				——————————————————————————————————————	- g50	0 10-1	9-10 VL	230	d. Date of d	elivery		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and appliety filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Exitical Certification: To Be Completed by Physician Page 2 and 2	2	3b. Was decedent pregna past 12 months? 1 Yes 2 No 9	Int in the	7	ant at time	of deat	- H	al death ner (Speci		Ectopic pregn	ancy		Month	Da	y Year	
P.O. B ss that the d gned by the e detached		Part II. Other significant (conditions	s contributing to	death but	not res	sulting in the u	nderlying	ause give	n in Part I.		_		_	e cause of death	
ords, F w requires to been sign should be	3										24a. Was	an	24b. We	ere auto	psy findings avail	lable
of Vital Records, P.C. ng Physician: The law requires that ther this certificate has been signed meral director, page 2 should be det no. To Be Completed by	5										auto perfo 1 ✓ Yes	ormed?	de	or to col ath? Yes	mpletion of cause	
Vital Rec ysician: The his certificate director, page	3 2	25. Was case referred to n examiner?	nedical	Hospital:		2	R/Outpatient		l Ott	Death (Check	only one)	ا ا	6	Other:		
ing Phys L. After thii funeral di	12	1 ✓ Yes 2 N 27. Manner of Death	lo	28a. Date	·		28b. Time of Ir		Bc. Injury a		28d. Describe	how inju	ury occurred	1	while	
Division ral or Attendii rs after death. ral Director: A led in by the fu		1 Natural 5 2 X Accident	Pending Investiga	ation 10-2-	-10		fd 1:5			2 X No	intoxic	ate	d		Route Number,	City
Division o Hospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the fune		3 Suicide 6 Homicide	Could no determin	ot be			beach	t, lactory,	omoe build	aling, etc.	or Town,	State)			ty, Md.	City
To the Hosp within 24 ho To the Fun completely	1 2			cian: To the best er:On the basis o	f examina	-										
To To To Com		29b. Signature and title of	certifier	and manner st	ated.			29c.	License n						h, Day, Year)	
		30. Name and address of p	-C 1	Hall	of of	/lton ^	232)		O.C.M.I	E.		Octo	ober 2, 2	010		
	'	Carol Allan, MD		tant Medical I	Examine	er 1	11 Penn S		altimore	e, MD 2120)1					
State Registra	ď	31. Date filed (Month, Day,		32. Re	gistrar's Si	gnature	barker									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32231 Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death October 2G10 Physician 12:05 AM Thelma 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 219-66-5239 53 Director Feb.1,1957 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director n/a Baltimore 10e. Street and Number 10g, Citizen of What Country 10f. Zin-Code 1829 Ν. Milton Ave. 21213 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☑ No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs <u>Mail Handler</u> U.S.Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Tate Thelma Blake ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherelle Tate (daughter) 1305 Pentridge Rd. Balto, Md. 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Garden of Faith Oct.16,2010 Balto,Md. nature of Funeral Service Licensee Zalvin B. Scruggs Funeral Home Preston St. Balto, Md. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events Examiner Due to (or as a consequence of): and burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical as the IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) igned by the at be detached for 1 Yes 2 No 9 Unknown Completed by Be ၉ Medical Certification;

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; I

Baltimore, Maryland 21215-0036

Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown					
		24a. Was an autopsy performed 1				
25. Was case referred to medical	26. Place of Death (Check only one)				
examiner? 1 ☐ Yes 2 🗖 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 Other (Specify)				
27. Manner of Death 17. Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?	d. Describe how injury occurred				
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	if. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exar	ysician: To the best of my knowledge, death occurred at the time, date and place, ar niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)				

29c. License number

RES-000

State Registrar 31. Date filed (Month, Day, Year) OCT 142010

29b. Signature and title of certifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2010

0.

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 8 48 PM ALBERT G. VOJIK 12 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedale Ballimore FRAnklin Sauac < Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1**⊠** M 2□ F Days Hours Min. Director 218 36 6847 70 11/10/1939 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE MD ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8003 CARADOC DRIVE 21237 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SPWHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ACCOUNTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT ၉ VOJIK SR MARIE KORDULA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trai BARBARA VOJIK /WIFE 8003 CARADOC DRIVE BALTIMORE, MD 21237
Disposition (Name of Date 20c. Location - City or Town, State 100 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FNIOMBMFNI PARKWOOD CEMETERY 10/16/10 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** disease Metastatic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

2 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES0000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel 9000 FRANKLIN SQUARE 21237 DR Balto AMER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 1 4 2010 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October Day 10, $^{\text{Year}}0$ 8:25 A M Evelyn Whitaker Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore 11 North Ann Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 01-12-7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country Days Hours Min. 1 M 2 X Director 75 225-42-5088 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Whitaker MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 USA 11 North Ann Street 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 5 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 **X**Vo 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 X Widowed 4 Divorced Specify: American Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Maryland Clothing Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA Presser Company Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walker Alice Pressev Roosevelt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11 North Ann Street Baltimore, MD 21231 Sharon D. Law-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date □ Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem. Pk. 10-16-10 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home F.A. Street Baltimore, MD 21217 21. Signature of Funeral Service 22. Name and Address of Facility 638 N. Gilmor 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
YEA-RS Physician/ CANCER COLORECTAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ★No 5 Other (specify) Dav Year Pregnant at time of death been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours affer death.

To the Funeral Director; Affer this certificate has completed filled in by the funeral director, page 2 s performed 1 ☐ Yes 2 🗶 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: Of the basis of examination allows in the state of the cause (s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 13, 2010 D0070620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21231 CHRISTOPHER KANAKEY, 40) NORTH BROADWAY BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) State OCT 14 2010

DHMH 17 Rev 7/2009

Registrar

Evelvn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07800 Kendra Chenae Wright 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 10, 2010 **Medical Examiner** 2133 hrs Kendra Chenae 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Catonsville **Baltimore County** 6517 Woodbridge Circle 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Director Country) MD 1980 13.98.4565 20 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location CatonsvIIIe Baltimore 1 Yes 2 No MD Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

part: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? Woodbridge Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? White etc. Yes Hack 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore. MD 21215-0036 Cashier almart tharade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) sandra Wright Be 19b. Mailing Address (Street and Number or Ryral Route Number/ City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) atmsville, MD 21228 Circle andra Wright Mother Codbyi 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2010 Woutus Wembrial Par 4 Donation 5 Other Specify: 22. Name and Address of Facility C. Greene Fundral Services Signature of Funeral Service Licensee Road Randallotown MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval **Physician** Between Onset and Madrett Death Immediate Cause Final disease a. Pneumonia Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). so the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -X UNPENDED #23a,27perME,G911,1/14/2011,WS Division of Vital Records, P.O. Box 68760. IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed by 2 2 should be detach ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Director: d in by the f 5 Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) e Funeral letely filled Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registra

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

Registrar's Signature

Assistant Medical Examiner

JR.

OCME

111 Penn Street, Baltimore, MD 21201

October 11, 2010

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010

		1	For State Registrar	Otato of W	ar yrarra 7		tificate of L				Reg. N	201	0 32	2235
Physi			1. Decedent's Name (First, Middle, Las Shirky Walls	st)					2.	Date of De Month		ay Year	2.11	of Death
-	edica minei		4a. Facility Name (if not institution, give UNIVLY SITY of Mary La	street and number)	Civite	V	4b. City, Town, o					c. County of De		
Fune			5. Social Security Number 6. S		e (In yrs. last b	oirthday)	If Under 1 Year Months Days		4 Hrs. 8.	Date of Birl (Month, Da LPT 17	th y, Year)	N/A	Birthplace (State	_
Direct		- 1-	Usual Residence of Decedent		79	Yrs.			ŞE	PT 17	, I	931	MI	
//aryland 8a-f she tified at	Director		MD 10b. County Anne Aru	ndel Co.	10c. City, To	en Bu							1	City Limits ∕es 2 € No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	j.	5	10e. Street and Number 700 Wimmer Road				10f. Zip Code	2106	.1		_	itizen of What (_	
death v r items	Finans		11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba			Yes or No- an, etc.)			nerican Indian,	-
0036 Irs after ural", o) A		1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X☐ If Yes, Give Year or Dates.	No	1	☐ Yes 2X No	Specify:				Specific	White	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	Completed		15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ducation ade co <i>mpleted)</i> College (1-4 or 5		(Give k	ent's Usual Occup ind of work done o NOT use retired)	during most o	of working			Kind of Busines	-	
d 21; ed withii Hygiene other th	P. C.		12 yrs. 17. Father's Name (First, Middle, Last)	College (1-4 of 5)uali	ty Contr			rst, Middle,		estingh	ouse	
yland de file Mental arked catic eve	1		Jasper Phelps					0s			urn	,		
Mar 2 shoul th and 27 is m		2.6	19a. Informant's Name/Relationship (T) Mr. Beacher Grant				g Address (Street a							
Jore, ge 1 and t of Hea if item or other		- 1-	20a. Method of Disposition		20b. Place	of Dispos	sition (Name of atory or other place	- :	Date			ocation - City		
altim mit. Pag partmen portant: / injury	oj.	-	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licens	(y)	Glen		n Mem. Pa							ion
a Tee	ouce.	1	· Wacc	$\overline{}$	01121	Se	rvices P	A; 1 2	nd Av	e SW,	G1			
Physicia	0/4	- 1	23a. Part 1. Enter the disease, or compshock, or heart failure. List only o Immediate Cause (Final disease or condition	on cations that caused ne cause on each line				g, such as ca	ardiac or res	spiratory arr	est,		Approxim Interval B Onset an	letween
Medic Examin	al		resulting in death)	Due to (or as a	consequenc	e of):	+D						2 week	2
	iner i		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequenc	e of);								
8760 Ifficate be executed g physician and as the burial-transit	Examiner		Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequenc	e of):								
8760 tificate be on ng physicial as the bur	Medical			d									-	
m			F FEMALE; 23b, Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		ath 3 🗆	Ectopic pregnanc	ev.				23d. Date of c		
b. Box the death of the atter ached for u	Physician/		1 Yes 2 Dec	4 Pregnant at 9 Unknown	time of death	n 5 🗆	Other (specify)					Month	Day	Year
Ital Records, P.O. Box 68 sician: The law requires that the death cert certificate has been signed by the attendir rector, page 2 should be detached for use			Part II. Other significant conditions of	ontributing to death but			, ,	en in Part I.				use contribute		
cord; w requi	Completed by				1,1					24a. Was a	an	24b. Were a	utopsy finding	s available
I Keco n: The law i ficate has b or, page 2 s			25. Was case referred to medical				00 5	(P - 1)		1 Yes	rmed?	death?		
VITA ysicia ysicia is certi	To Be		examiner?	Hospital:	nt 2 🗆 ER/0	Outpatient	Othe	ace of Death er: 4 Nurs	,		lence (6 ☐ Other_(Spe	ecify)	
Division of Vital Records, tal or Attending Physician: The law requires is after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be	Certificate:		27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,		. Time of injury	28c. Injury work M 1 🗆	/ at	28d.	Describe h				
IVISIC lor Atte after des Directol	Certif		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			farm, stre	et, factory, office			Location (S City or Tow		nd Number or F	ural Route Nur	nber,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	-	(Check 2 L Medical Exami	sician: To the best of r ner: On the basis of ex	amination and	d/or investi	gation, in my opinic	n, death occu	urred at the	time, date a	nd place	e, and due to the	e cause(s) and r	nanner stated.
To the within To the comple	Σ		only one) 3 Certifying Nurs	e Practioner: To the b		owiedge, de	29c. License				29d. Da	ite signed (Mor	th, Day, Year)	
		3	80. Name and address of person who c) (Type, Pr						JU 13/		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32236 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Claudette Woolley Physician/ October 2010 9:24pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Nursing Home & Rehab Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Days Hours 092-38-7405 66 Director Haiti Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director CD Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3923 7th Street NE Apt. 20017 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1X Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black Specify 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Customer Service Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stephan Woolley Sr. Marie Martha Cassagnol 19a. Informant's Name/Relationship (Type, Print)

Jacqueline Brown/Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2246 Sanibel Drive, Reston, VA 20191 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/09/2010 Woodbine.MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service License Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician CONUNARY BATERY MKASE CAMWAYUPAM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated so or in.) Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 ☐ Yes 24 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYDENTENSON, MYANTHYMIDISM. 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Comment GENER IN WER CHENTY 24a. Was an autopsy performed? Yes 2 this certificate has funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2**X X**IO Hospital: Other: XXNursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred After injury 5 Pending 2 Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 3 29b. Signature and title of certifie of death (Item 23a) (Type, Print) 106 INVINCE WASHING W A C. LUST 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of pers

31. Date filed (Month, Day, Year)

OCT 14 2010

U. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106

Registrar's Signature

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Jeannette Frances Wilkins 1:36 P.™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1474 Pleasantville Drive Anne Arundel Glen Burnie 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Months 1 🗆 M 2 🕱 F Hours Month, Day, Year) 09/15/1916 212 16 3885 94 Maryland Yrs. Director Usual Residence of Decedent show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If item 27 is marked outher than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Anne Arundel Glen Burnie Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1474 Pleasantville Drive 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 9th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas H. Griffiths Adell Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wilkins / Son 1474 Pleasantville Drive Glen Burnie, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I 1 🗷 Burial 2 🗌 Cremation 3 🗍 Removal from State Important: If any injury or Glen Haven Mem. Park! 10/12/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due o (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-trans To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 4 9 Unknown the a g Unknown signed by Part II<mark>. Other significant conditions</mark> confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Latural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-11-2010 30. Name and address of person who completed cause of death (hem)23a) (Type, Print) C.V. CYKIAC. M.D.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct. Physician/ 2010 Richard H. Winkelman 12. 3:40A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7053 Wolftree Lane Rockville Montgomery 8. Date of Birth (Month, Day, Jan. 3, Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Min. Hours Washington, DC Director 91 1919 577-10-3359 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7053 Wolftree Lane 20852 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Examiner Armed Forces? ō Black, White, etc. Completed by 1 Never Married 2 X Married ^{2 □ No} World Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates War I the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 4 Executive is marked other <u>Insurance</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Winkelman Amelia Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Peter A. Winkelman/Son 12514 Hialeah Way, North Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Rock Creek Cemetery 4 Donation 5 Other (Specify) 2010 Washington, DC Robert A. Chase, Inc. Pumphrey Funeral Home/ 7557 Wisconsin Avenue 3501 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc Bethesda, Maryland 20814 M01607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Hypertensive Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of): [£]Examiner Atrial Fibrillation Securatelly list to adition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Severe Aortic Stenosis Due to (or as a consequence of) resulting in death) Last Physician/Medical Cerebrovascular Accident Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No as been signed by the 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\tilde{\Delta}\) No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗓 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify, . Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License numbe 5× www D0047330 October 12, 2010

Registrar DHMH 17 Rev 7/2009

State

50 West Edmonston Drive, Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Thomas V. Joseph, M.D.

1 4 2010

(Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Williams 1910 M bero Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye May 30, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 251-42-7232 Months Hours 78 Director 1932 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2417 Lauretta Avenue 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black If Yes, Give 3 Divorced 4 Divorced Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Construction Worker Construction 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Samuel Williams Vermell Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Joyce Williams/Wife 2417 Lauretta Ave. Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Mt. Carmel Cem 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/14/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ature o Funeral Service Licensee 22. Name and Address of FacilityBeverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequence of): Yreamonia disease or condition resulting in death) Medical Examiner hagin Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine erebrovascu Hospital or Attending Physician: The law requires that the death certificate be executed eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Visease pronur 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? hronic 24a. Was an after death.

Director: After this certificate has be autopsy performe 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Acciden Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

State Registrar

only one 29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

DHMH 17 Rev 7/2009

Smith Avenue St 203

D0053337

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 27,2010 **Physician** Thurman Sizer Alphin 12:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmore Assisted Living Washington County Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1**∑** M 2□ F 229-18-0080 93 **Director** 29,1917 Virginia Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire Medical Exemprer must be reflied at Completed by Funeral Director 1 ☐ Yes 2 ☐ No MD Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14004 Pennsylvania Avenue 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 😿 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Mechanic Aircraft Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Washington Alphin Hettie Lucinda Sizer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. Thurman L. Alphin / Son Greencastle, PA 17225 493 Pensinger Rd. 20b. Place of Disposition (Name of cemeterv. crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park Oct. 4,2010 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signifure of Funeral Service Licensee 1331 Eastern Blvd. North, Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause I Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Onset and Death **Physician** /Medical **Examiner** candrony Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) as been signed by the 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06039 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNSAED 5H-3 D Gogrado 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State 30 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 32241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 124 PM 2010 F. Harold Anderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARK MKOMA MONT GOMER HUSPIM WASHINOW TIMBUCA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Sept. 12, 1 X M 2 □ F 72 Months Hours Min. Country) Director 578-50-2329 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Riverdale Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò ural", or items 23a o Examiner must be Funeral 20737 United States 6827-A Riverdale Rd. # 201 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. Black 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give than "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) and Mental Hygiene. Transportation Worker Government be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or our ည Thomas Anderson Maude V. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6827-A Riverdale Road #201 Riverdale, Md. 20737 Delores M. Anderson - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ober 1, 4 Donation 5 Other (Specify) Maryland National Laurel, Maryland tyre of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Sig W 20019 4001 Benning Road NE Washington, DC 23a. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carolinus Physician/ An disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONI Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown the 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed I 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate h perform 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 욘 1 Inpatient 2 🕒 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner # 28a. Date of injury (Month, Day, Year) Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b ignatur d title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, 1

Canal Nenue

600

address of person who completed cause of death (Item 23a) (Type, Print)

09-27-2010

MAKUMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32242 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Month RUNETT Year () Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ≠ M 2 □ F *3*77674931 Director 117-22-0161 79 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Severn Ave. 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 🙀 Married 2 2 □ No Korean YX Yes If Yes, Give Maryland 21215-0036 1 Yes XX No Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) CEO AAMC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Brunetto Leatrice Ruggeri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Hughes Daughter 814 Moran Dr. Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗋 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 9/28/2010 Glen Burnie, MD Signature of Funeral Septice Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 70 Ridgely Ave. Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line, as cardiac or respiratory arrest, Approximate Injerval Betwee Immediate Cause (Final Physician/ set and a eath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exami executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Director: After this certificate has autopsy performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2- No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred √Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours after To the Funeral Direct edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one Signature and title of certifier 29e Date signed (Month, Day, Year) +38 and address of person who completed dayse of death (Item 23a) (Type, Print) M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar		State of IVI	aryianu /	•	tificate of L		and w	_	Reg. No	2010	32	243
	Physicia		1. Decedent's Name (t)						2. Date of De Month	eath 186	22 m		of Death 95 7 M
	Medic Examin		4a. Facility Name (if no		street and number)			4b. City, Town, or	Location	of Death	ET (EI)		c. County of Dea	, ,	
an select			Baltimore					Glen Burnie					Anne Arundel		
	Funeral Director		5. Social Security Nun 231-38-919 Usual Residence of D	91 12	7. Age	76	oirthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 2/4/	1934	9. Bii	thplace (State ountry) KY	e or Foreign
7	show at	ě		10b. County		10c. City, To	wn or Lo	cation						10d. Inside	City Limits
7	waryii 28a-f	Director	MD	Anne Arı	undel		Sev	ern						1 □ Y	∕es 2 K No
4	Sa or S		10e. Street and Numb					10f. Zip Code				10g. C	itizen of What Co	ountry?	
4	ms 2%	Funeral	1122 Reece	e Rd.	12. Was Decedent E	ver in LLC	142 1		144	igin? (Span	ifu Voc or No		USA	t - to dies	
2-003b	permit, rage I and 2 should be lined whitin 72 hours aner dean with the maryland popularment of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4		Armed Forces? 1 Yes 2 Yes If Yes, Give Year or Dates.			Vas Decedent of Hi FYes, specify Cuba			ican, etc.)		14. Race - Ame Black, Whit Specify:		
ביים ביים	ויין אר וויין. edica	Completed		15. Decedent's Ed fy only highest gra		10	(Give I	ent's Usual Occup	ation during mos	it of working	g	16b. k	Kind of Business	Industry	
7	iene. sr thar the M		Elementary/Secon	nday (0-12)	College (1-4 or 5	+)	life. Do	O NOT use retired) Clerk				Sh	ipping/	Reciev	/ing
3	snould be liled vined with and Mental Hyg	To Be	17. Father's Name (Fit UNK	'. Father's Name (First, Middle, Last) UNK Barnes					18. Moth		(First, Middle,				UNK
a	and M is ma aumat		19a. Informant's Nam	ne/Relationship (Ty	/pe, Print)	1	9b. Mailin	g Address (Street a	and Numbe	er or Rural	Route Numbe	er, City o	r Town, State, Zi	p Code)	
e, ≤	Health tem 27		Teresa Lit		Friend			Reece Rd.	. Se						
Imore	trifite			Cremation 3	Removal from State	ceme	tery, cren	sition (Name of natory or other plac	· i		ate		ocation - City or		
Baltimor	permit, rage Department Important: I any injury o once,		4 ☐ Donation 5	odher (Specif		lChurc	h of	God Ceme	etery ss of Facilit	9/27	/2010	Gar	brills,	_Md	
ם מ	Depar Import any ir		Date	1 11			8	. Name and Addres	lis	Rd. G	esty r ambril	unei 1s,	MD 2105	4 P.A.	
Z PI	nysician/		shock, or heart Immediate Cause (Fi disease or condition	failure. List only o	pilications that caused ne cause on each line			r the mode of dying			respiratory ar	rest,		Approxim Interval B Onset an	etween
'E	Medical xaminer		resulting in death)	ſ	to (or as a	consequenc		(FficiE)							
		iner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate M	b. Due to (or as a	consequenc	e of):	RILLA-							
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r ou	sician a	cal E	resulting in death) La	L	Due to (or as a	consequenc	e 01).								
o / oO	g phys				d										
. DOX OC	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Physician/N	IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	23c. If yes, outcome of 1 ☐ Live Birth 1 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de		Ectopic pregnanc Other (specify)	У				23d. Date of de Month	livery Day	Year
Joy P.O	n signed by	by	Part II. Other signification	ant conditions co	ontributing to death bu	ut not resultin	g in the u	nderlying cause giv	en in Part	1.			use contribute to		
he law requires	te has bee age 2 shou	Completed									24a. Was autor perfo		death?	topsy finding completion o	
	ertifica ctor, p	Be C	25. Was case referred examiner?	/	/			26. Pla	ace of Dea	th (Check o		2 (3)	0, 12.10	2 2 110	
Physic	this or al dire	욘	1 Yes 2 2	No		ent 2 ER/			4 ∐ Nı				6 ☐ Other (Spec	cify)	
tending P	leath. Ior: After the funer	Certificate	1 ☑ Natural 2 ☐ Accident	5 Pending Investigation 6 Could not be		Year)	. Time of injury			No	d. Describe h	,			
ital or Attend	urs after or ral Direct lled in by		4 🗌 Homicide	determined	building, etc	(Specify)					City or Tow	vn, State			nber,
the Hosp	the Fune	Medical	only one) 3	Medical Exami	sician: To the best of r ner: On the basis of ex se Practioner: To the b	amination and	l/or invest	igation, in my opinic	n, death oo	ccurred at the	ne time, date a	and place	e, and due to the	cause(s) and r	manner stated.
, p	To vith		29b. Signature and titl	le of certifie	CHS	NO		29c. License	number 5(49	<u> </u>	29d. Da	tews	h, Day, Year) e/22	2010
ſì.	44		30. Name and address		ompleted cause of de	eath (Item 23a		rint) re G	len	Bu	mil	W	1) 2	0161	•
	Stat Registra	te ar	31. Date filed (Month			Signature	h	exel	-						- <u> </u>

State of Maryland / Department of Health and Mental Hygien []

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 25 2010 **Physician** September Susan Sayre Brubacher 1:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Eden House Hospice Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 31 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☐ M 2 X F 66 577-58-9805 Washington, D.C Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other treumatic event, If a M-dical Exactline Inval Execution 2022. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 01ney 1 Yes 2 No Md. Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832 United States 3714 John Carroll Drive Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) County Government Historic Preservation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marguerite Suit Eugene Fauntleroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond A. Brubacher / Husband 3714 John Carroll Drive, Olney, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ Removal from State 9/27/10 Alexandria, Virginia Metropolitan Crem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Furgeral Service Livense 22. Name and Address of Facility.
Muriel H. Barber Funeral Home -00470 P. 0. Box 5038, Laytonsville, Md. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 7 Years Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Yes 2 ☑ No this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 3010 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 18111 Prince Philip Dr., Suite 300, Olney, Md. 20832 David B. Harding, M.D. 15 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Chroun Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25perME. G909, 11/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Physician/ 2010 EDITH V. BRANCH SEPTEMBER 10:25 PM Medical 4a. Facility Name (if not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL 4b. City, Town, or Location of Death CLINTON Examiner 4c County of Death
PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 - M 2 X F JULY 4, 1 WEST VIRGINIA Director 1̈́91<u>1</u> 575-07-8791 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S TEMPLE HILLS 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3420 RICKEY AVENUE #141 20748 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6TH CAR CLEANER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ HENRY WALLACE BERTHA DAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY JONES/DGT 3420 RICKEY AVENUE #141 TEMPLE HILLS, MARYLAND 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place CHURCH CEMETERY 10/1/2010 BRANDYWINE, MARYLAND 21 Signature of Fund Service Licensee J. B. JENKINS FUNERAL HOME, INC 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascu Medical resulting in death) Examiner Hypoxic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (b as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): by the attending physiciar Physician/Medical Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month page 2 should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 No prior to completion of cause of death?

1
Yes 2
No this certificate of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 43446 Part SEPTEMBER 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

ROINTAN

31. Date filed (Month, Day, Year) SEP 3 0 2010

3

FARAHIFAR

32. Registrar's Signature

12150 Annapolis road

Suit 3/2 Clem del MO 20769

			For State Registrar	State of Maryl		artment o <i>tificate o</i>		and Mental Hy	giene Peg. No.	32246
			Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	3. Time of Death
Н	Physicia Medio		WILLIAM	BARNE	R			Month SEPTEME	$3ER^{Day}27$, 201	
***	Examir		4a. Facility Name (if not institution, give	street and number)		4b. City, Towr	n, or Location o	of Death	4c. County of De	
	<u>'. </u>		8015 MANDAN RO				ENBELT			GEORGE'S
	Funeral Director		Social Security Number 6. Se 1	ex □XM 2 □ F	rs. last birthday) Yrs.	If Under 1 Ye Months Da		Min. (Month, Da	th 9. B	irthplace (State or Foreign country) EORGIA
	. 3		258-44-1222 Usual Residence of Decedent					AUGUST	10. 1929 G	EORGIA
	and shov	to	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f otifie	rec	MD PRINCE G	EORGE'S	GREENBEI	Γ				1 X Yes 2 □ No
	a or	Funeral Director	10e. Street and Number			10f. Zip Coc	de		10g. Citizen of What 0	Country?
	h with	ner	8015 MANDAN ROAD			2077			USA	
	r iter iner		11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of f Yes, specify C	of Hispanic Orig Suban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Am Black, Wh	
336	s after al", o Exam	d b	1 Never Married 2 Married 3 Divorced	1 💭 Yes 2 □ No A If Yes, Give Year or Dates.	KMY .	I ☐ Yes 2√	No Specify:		Specify:	BLACK
21215-0036	hours natur lical I	Completed by	15. Decedent's E	ducation	16a. Deced	dent's Usual Oc	cupation		16b. Kind of Busines	s Industry
218	in 72 e. nan "l	틹	(Specify only highest gra	College (1-4 or 5+)	(Give	kind of work do O NOT use retir	ne during most red)	of working	1	•
2	with ygien her th	ပ္ခဲ	7th		POS	TAL SEF	RVICE		GOVERNME	NT
nd	e filec ntal H ed ot even	To Be	17. Father's Name (First, Middle, Last)					er's Name (First, Middle,	Maiden Surname)	
Z	uld b d Mer mark natic		WILLIAM HENRY BA				ONIE			
Maryland	2 sho th an 27 is trau		19a. Informant's Name/Relationship (T) JUNE PARKER BARN		I				er, City or Town, State, 2 BELT , MARYLA	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		b. Place of Dispo	sition (Name of	· I	Date	20c. Location - City of	
Baltimore,	age ent o		1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			natory or other p		10-6-2010	CHELTENHAM	
altii	mit. F partm porta / inju		21. Signature of Funeral Service Licens						CINS FUNERA	
m	permit Depar Impor any in		1		7	474 LAN	NDOVER	ROAD HYATTS	SVILLE, MARY	LAND 20785
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the cone cause on each line.	leath. Do not ente	er the mode of o	dying, such as o	cardiac or respiratory ar	rest,	Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	CHRONIC O	BSTRUCT	EVE PULI	MONARY	DISEASE		Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
		er	Sequentially list conditions,	CHRONIC R		SEASE				
	ed	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury but in iinjury DIABETES MELLITUS							
	xecut n and al-tra	Exa	that initiated events resulting in death) Last	c. DIABETES Due to (or as a cons						
09	ate be executed bhysician and the burial-transit	dical Examiner		d						
876	ificate I ig phys as the	Med	IF FEMALE:							
Box 687	ath certifica attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre		Ectopic pregn	nancy		23d. Date of d	,
Bo	deat the at ned fo	/sici	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)		Month	Day Year
P.O.	es that the des signed by the a I be detached f	Completed by Physician/Me	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause	e given in Part I.	. 23e Did t	obacco use contribute	to the cause of death?
S,	signe d be c	d b	_		-	, ,				Probably 4X Unknown
ord	v require s been si should I	lete						24a. Was	an 24b Were a	utopsy findings available
ecc	sician: The law is certificate has birector, page 2 s	щ						auto	psy prior to prmed? death?	completion of cause of
E	sician: The certificate I rector, pago		25. Was case referred to medical			26	S. Place of Deat	1 Tyes	2 X No 1 □ Y	es 2 🔀 No
Vit	ysicia is cer direct	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	_ (Other:		dence 6 Other (Spe	ecify)
o	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year	28b. Time of injury		njury at vork?		now injury occurred	
ion	tendii leath. or: Af the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be				☐ Yes 2 ☐	No		
Division of Vital Records,	or Att	Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ec <i>ify)</i>	et, factory, offic	ce	28f. Location (S City or Tov	Street and Number or R vn, State)	ural Route Number,
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours afferd death. Funeral Director, feet this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director.		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge death	accured at the t	ime date and n	aloos and due to the co	usea(e) and manner as s	tated
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Exami		ation and/or invest	igation, in my op	oinion, death oc	curred at the time, date a	and place, and due to the	e cause(s) and manner stated
	To the within 2 To the comple	2	29b. Signature and title of gertifier	V .	\		ense number		29d. Date signed (Mor	
			> Clintoken	M	. A.	Do	0062	141	89/29/	2010
n	5		30. Name and address of person who c						1 1	
1			OLUMIDE COKER M			LANE L	ARGO,MA	RYLAND 207	74	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra's Sig	Market !					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32247 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 25 George W. Chase Jr 0501 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 1 **X** M 2 \square F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Ju Yy Tab Hours Year 954 56 Maryland 212-66-5355 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🔀 No ö 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? 159 Brightwater Dr. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give Black, White, etc. ō ş 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Divorced 4 Divorced **Black** Completed Year or Dates al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian St. John's College 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event; it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George W. Chase Sr Marnette E. Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane M. Chase(Sister) 159 Brightwater Dr. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9 - 28 - 10Metró Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mindame Reaches Of Milit Sons Mortuary, P.A. 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a sonsequence or): ulmon Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by toulune Kanal 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pade performed? Yes 2 No Director: After this certificate 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes → No Hospital Other: မှ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury Natural 2 Accide 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 743311

DHMH 17 Rev 7/2009

Registrar

JVa

AAMC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Herber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 4:16 PM 01ga I. Cherot 0 Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WICOMICO SALISBURY DASTAL HOSPEE AT THE LAKE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 2-16-1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months New York **Director** 099-22-7135 Usual Residence of Deceden items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD Salisbury Wicomico 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 5567 Channel Drive filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No 1 ☐ Yes 2 🔀 No Specify: Russian "natural" 3 X Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be filed and Mental H ဥ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Battle Mable Hatcher <u>Clarence</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6181 Diamondback Drive, Salisbury, Maryland 21801 Dorothea Haac - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 9-30-2010 Delmar, Delaware 22. Name and Address of Facility Signature of Funeral Service Ligenses Bounds Funeral Home Milla 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or conshock, or heart failure. List of polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ CHRONIC DBSTRUCTIUR MLMONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 ponths? ☐ Live Birth ∠ ☐ 1 616. 321. ☐ Pregnant at time of death ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? Frostruction after death.

• Funeral Director, After this certificate the funeral director, pag Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: Certificate: To HOSPIC12 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes Natural 5 Pending 2 Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. only one Certifying Nurse Practioner To the best of my knowledge of et the time 29b. Signature and title of certifier 8410

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:34p Henry H. Culler, 2010 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kline Hospice House Airy Frederick 9. Birthplace (State or Foreign Country)
Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 22, 1944 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 🗆 F **Director** 215-42-4182 66 May Usual Residence of Decedent 28a-f shov death with the Maryland "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 K No Maryland Frederick **Knoxville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3505 Petersville Road 21758 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian þ 1 Never Married 2 Married X Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1963-69 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Painter Auto Body is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked o Henry H. Culler Sr. Dorothy Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Michelle Love / Daughter 10719 Green Valley Road, Union Bridge, Maryland21791 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 9/28/2010 Frederick, Maryland 21. Signature deral Service Licens 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ner if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Directo for esta por sequence of Exami The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 2 🗌 No Yes 2 N 1 🗌 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spec 4 Nursing Home 5 Residence 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gettifying Nurse Practioner: To the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 48184

5 + IVA

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who comp

Eskander

Elhamy

Street Frederick, MD

pleted cause of death (Item 23a) (Type, Print)

ar's Signature

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month September Physician/ HENRY BRUCE CRANFORD SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) Sep. 29, 1919 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1² M 2 □ F Hours Min. Director 90 Yrs. 433-18-4254 Usual Residence of Decedent fshow "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Adams town County Frederick Funeral Director 10e. Street and Number 3200 Bakers Circle 10f. Zip Code 21710 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 Married 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Midowed 4 □ Divorced Completed Year or Dates. 1938-69 traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

Is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Master Chief Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ္က Annie L. Smith Henry W. Cranford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen W. Cranford 6104 Fieldcrest Dr., Frederick, MD 21701 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Oct. 4, 2010 Gate of Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each tine. Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical Due to (of as a consequence of):

Examiner

e Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

	Examin
	ertificate: To Be Completed by Physician/Medical Examin
	oy P
	Completed I
	Be
	10
100	ertificate:

Medical

bondly

PRATIMA PANDEY

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28

32. Registrar's Signature

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Renal Failure Due to (or as a consequence of): c			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underl	ying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed 1 Yes 2	
25. Was case referred to medical examiner?		26. Place of Death (Check	only one)	
1 Yes 2 XNo	Hospital: 1 Springatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hor	ne 5 🗆 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 M Natural 5 Pending 2 Accident Investigation		work?	8d. Descrîbe how in	jury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
(Check 2 Medical Examin	ician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation e Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at	the time, date and pla	ice, and due to the cause(s) and manner state
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

400 West 7th Street, Frederick, MD 21701

32250

6:40 AM

3. Time of Death

9. Birthplace (State or Foreign

Texas

10d. Inside City Limits

1 Yes 2 No

2010

FREDERICK

Country)

4c. County of Death

10g. Citizen of What Country?

Specify:

U.S. Navy

16b. Kind of Business Industry

20c. Location - City or Town, State

9-26-2010

Silver Sring, Maryland

Interval Between

Onset and Death

14. Bace - American Indian Black, White, etc. White

Registrar

State

s after death.

I Director: Af d in by the fu filled in by 24 hours a

To the within 2

9+IVA

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of N	Maryland		artment of H Hificate of D			7	010	32251	
_		Registrar 1. Decedent's Name (First, Middle	e, Last)		001	tineate of E	Catri	2. Date of De	Reg. No. `		3. Time of Death	
Physicia Media		JOHN		CHA	SE	JR.		SEPTEM	BER ^{Pay} 27	20°10	4:10 A M	
Examir	er	4a. Facility Name (if not institution 9507 CAS))		4b. City, Town, or UPPER 1	Location of Death	1	1	4c. County of Death PRINCE GEORGE'S		
Funeral Director		5. Social Security Number 578-30-3847	6. Sex 1 □ MM 2 □ F	Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JAN 27	th y, Year)		place (State or Foreign try) LAND	
		Usual Residence of Decedent										
aryland a-f she fied at	Director	10a. State 10b. County MD PRING	CE GEORGE'S		, Town or Lo	IARLBORO					0d. Inside City Limits 1 Yes 2 No	
the Ma or 28 e noti	Dir.	10e. Street and Number				10f. Zip Code		1	10g. Citizen	of What Cour		
is 23a nust b	Funeral	9507 CASTLE DI	RIVE			2077	72		USA			
errift. Page 1 and 2 should be filed within 72 hours after death with the Maryland errift. Page 1 and 2 should be filed within 72 hours after death with the Maryland es artment of Health and Mental Hygiene. Inportant If item 27 is marked other than "natural", or items 23a or 28a-f show mining or other traumatic event, the Medical Examiner must be notified at nre.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐️XMai 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	Armed Forces? 1 X Yes 2 □ No ARMY If Yes, Give		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2X No Specify:			E	14. Race - American Indian, Black, White, etc. Specify: BLACK		
2 hour	Completed		ent's Education est grade completed)		(Give	Decedent's Usual Occupation (Give kind of work done during most of working			16b. Kind o	f Business In	dustry	
/ithin 7	Con	Elementary/Seconday (0-12) 7 TH	College (1-4 o	r 5+)		O NOT use retired) CK DRIVER			PRI	VATE		
filed v al Hyg d othe	Be c	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Middle,				
VICE VICENCE Should be file by and Mental F7 is marked or iraumatic eve	욘	JOHN S. CHASE						GARY	_			
hd 2 sho ealth and m 27 is r		19a. Informant's Name/Relations AUDREY JORDAN			9507	ng Address (Street a	ORIVE U	PPER MAF	RLBORO,	n, State, Zip (MARYLA	AND 20772	
diffillioned and an armit. Page 1 armit. Page 1 armit. Page 1 armit. If ite profrant. If ite y injury or office.		1 V Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)								on - City or Town, State		
errit. erartr mports any inju	1.3	21. Signance of Funer Service	Licen	0.1	100	Name and Address	,				AND 20795	
_	\vdash	23a. Part 1. Enter the disease, o							-	MAKILE	Approximate	
**Physician/ Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. META			STATE CAN	CER			-	Interval Between Onset and Death	
Examiner	-e	Sequentially list conditions,	b. —									
ted I nsit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	s a consequ	ence oi);							
r ou cate be executed physician and the burial-transit	edical Examiner	that initiated events c. Due to (or as a consequence of):										
ate be	dica		d			<u> </u>						
In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me									23d. Date of delivery Month Day Year		
s that t gned b	Š	Part II. Other significant conditi	ons contributing to death	but not resu	ulting in the u	underlying cause giv	en in Part I.				he cause of death?	
ecords, s law requires thas been sig	eted			-				24a. Was			bably 4 💢 Unknown psy findings available	
Te law e has l	Completed							auto	psy ormed?		mpletion of cause of	
VILAI F rsician: TI s certificat director, pa	BeC	25. Was case referred to medical examiner?				26. Pla	ace of Death (Che		2451 NO	I 🗆 Ies	2 E3 NO	
hysic this ce al dire	은	1 Yes 2 No				nt 3 DOA Othe	4 L Nursing F	lome 5 K Resi)	
Attending P r death. sctor: After to y the funerary	cate	27. Manner of Death 1 Natural 5 □ Pendi 2 □ Accident Invest	28a. Date of ir ng (Month, L igation		28b. Time of injury	work	rat ? Yes 2 □ No	28d. Describe I	now injury occ	curred		
or Atter after dea Director in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of I	njury - At hor etc. (Specify)		eet, factory, office		28f, Location (City or Tov		mber or Rura	l Route Number,	
n 24 hours are Funeral loleted filled	Medical	(Check 2 Medical)	g Physician: To the best Examiner: On the basis o g Nurse Practioner: To the	f examination	and/or inves	tigation, in my opinic	n, death occurred	at the time, date	and place, and	due to the ca	use(s) and manner stated.	
To the company of the	_	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor D62885 SEPTEMBER										
6		30. Name and address of person										
- J		SONJA WYCHE 31. Date filed (Month, Day, Year)	M.D. P	0 B	OX 844	42 RESTON	, VIRGIN	IA 2019	5			
Sta Registr		OCT 0 1 2010	Beneva > B	trar's Signati	west .							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Freddie Fields ä 5:10 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montomery Hospice Rockville 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 1 XM 2 □ F Hours 422-14-7504 87 Yrs Director ALA 8-8-1923 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PG Hyattsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 702 Sheridan St. 20783 U.S.A. 12. Was Decedent Ever in U.S.

Armed Forces?

1 M Yes 2 □ No 1943

If Yes, Give Year or Dates. 1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Private Supervisor Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve ည Henry Fields Carrie Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greig Fields (Son) 1604 Dickens Pl. Upper Marlboro MD. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Harmony Mem"l Cem 10-4-2010 Hyattsville MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hunt Funeral Home Signature of Funeral Service Licenses Hunt Francis 3. 908 Kennedy St. N.W. Wash, 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Intracerebral Hemmorrhage disease or condition Days Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension vears Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 2 No. g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica BB 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner. Of the basis of examination arrows graden, many spanish and place, and due to the cause(s) and manner as stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 37142 9-29-2010

State Registrar Piccard Dr. Rockville MD.

20850

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

1355

Coleman

31. Date filed (Month, Day, Year) SEP 3 0 2010

Director 4/2-46-2813 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Washi 10f. Zip Code	A MONTGOMERY
LARKT GENE FRIESEE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of NATIONAL NAVAL MEDICAL CENTER BETHESI	Death 4c. County of Death MONTGOMERY Hrs. 8. Date of Birth (Month, Pay, Year) Aug. 9, 1942 9. Birthplace (State or Foreign Country) Nebraska
Funeral Director 4a. Facility Name (if not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER 5. Social Security Number 47.2-46-2813 45. City, Town, or Location of BETHESI BETHESI 7. Age (in yrs. last birthday) 47. Age (in yrs. last birthday) 48. City, Town, or Location of BETHESI 49. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 41. Explication of Days Hours 45. Social Security Number 47. Age (in yrs. last birthday) 47. Age (in yrs. last birthday) 48. Facility Name (if not institution, give street and number) 49. City, Town, or Location of BETHESI 49. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 41. Age (in yrs. last birthday) 42. Facility Name (if not institution, give street and number) 44. Facility Name (if not institution, give street and number) 45. City, Town, or Location of BETHESI 46. City, Town, or Location of BETHESI 47. Age (in yrs. last birthday) 47. Age (in yrs. last birthday) 47. Age (in yrs. last birthday) 48. City, Town, or Location of BETHESI 49. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 40. City, Town, or Location of BETHESI 41. City, Town, or Location of BETHESI 42. City, Town, or Location of BETHESI 43. City, Town, or Location of BETHESI 44. City, Town, or Location of BETHESI 45. City, Town, or Location of BETHESI 46. City, Town, or Location of BETHESI 47. Age (in yrs. last birthday)	Hrs. 8. Date of Birth (Month, Pay, Year) Aug. 9, 1942 Nebraska
Funeral Director 5. Social Security Number 472-46-2813 6. Sex 1 Age (In yrs. last birthday) 68 Yrs. 7. Age (In yrs. last birthday) 68 Yrs. 68 Yrs.	Hrs. 8. Date of Birth Min. Aug. 9, 1942 9. Birthplace (State or Foreign Country) Nebraska
Director 472-46-2813 1 A 2 F 68 Yrs. Months Days Hours Usual Residence of Decedent	Min. Aug. 9, 1942 Country Nebraska
Lisual Residence of Decedent	
The purpose of the pu	10d. Inside City Limits
Washi	
10e. Street and Number 10f. Zip Code 10f.	ngton 1 🗷 Yes 2 🗆 No
- F XX F A TENT T T #799 9700 Manaba Calaba 1 0 mm 1	10g. Citizen of What Country?
AFRH W #733 3700 North Capitol St. NW 20011-84	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 □ Never Married 2 ⚠ Married 1 □ Never Married 2 ☒ Married	
1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 New No. Specify: 1 Never Married 2 Married 1 Never Married 2 New No. Specify: 1 Never Married 2 Married 1 Never Married 2 New No. Specify: 1 Never Marr	Specify: White
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N S 5 5 5 5 6 0 17. Father's Name (First, Middle, Last) 18. Mother's	nician Government Name (First, Middle, Maiden Surname)
Leonard W. Friesel	Gladys R. Bryant
Elaina Friesel Garvin - Daughter 3001 Ontario Circl	er Rural Route Number, City or Town, State, Zip Code) Le East Melbourne, FL 32935
The state of the s	pt • 30,
Lee's Crematory 20	10 Clinton, Maryland
Se Burial 2 Sa Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1. Signature of Funeral Service Licensee 20. Place of Disposition (Name of Cermetery, crematory or other place) 1. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Ro	Stewart Funeral Home, Inc. ad NE Washington, DC 20019
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	Interval Between
Immediate Cause (Final disease or condition resulting in death) Medical STAGE III ADENOCARCINOMA OF THE	ESOPHAGUS Onset and Death
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
equire een s eurire pould en seu s equire een een s equire een s equire een s equire een een en equire een een en equire een een en equire een een een een een een een een een e	1 Yes 2 No 3 Probably 4 Unknown
The law requires page 2 should be completed.	24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
Y P sp 80 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 Yes 2 No 1 Yes 2 No
26. Place of Death examiner? 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	ng Home 5 □ Residence 6 □ Other (Specify)
27. Manner of Death 28b. Time of injury (Month, Day, Year) 28b. Time of injury work?	28d. Describe how injury occurred
The state of the	
28c. Injury at work? 1	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and plated the control of	rred at the time, date and place, and due to the cause(s) and manner stated.
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date are provided by the second of the secon	d place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
9900650 (N	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL	NAVAL MEDICAL CENTER
COLLEEN DORRANCE CDR MC USN BETHESDA	MD 20889-5600
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	

DHMH 17 Rev 7/2009

			State of Maryland / Dep	partment of Health and ertificate of Death		_ / !!!!!	32254
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	g. No.	3. Time of Death
	Physicia Medic		Christine Ferguson		Month September	Day Year er 25,2010	7:18 P. M
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
**************************************	Emanuel		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Sprin		Montgo	
	Funeral Director		577-74-6051 1 M 2 X F 55 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	rear) Cour	place (State or Foreign htry)
	d t	L	Usual Residence of Decedent		100/30/13		
	arylan a-f sh fied a	ecto	D.C. 10b. County 10c. City, Town or L				10d. Inside City Limits 1 Yes 2 □ No
	the M or 28 e noti	ä	10e. Street and Number	10f, Zip Code	10	g. Citizen of What Cou	
	s 23a sust b	Funeral Director	7533 9th St.,N.W.	20012		U.S.A.	,
	death r item ner n		11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces? 13	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,	
38	after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:	, , , , , , , , ,	Specify: Af	rican—
Ö	hours natur dical b	Completed	15. Decedent's Education 16a, Dec	edent's Usual Occupation	1	6b. Kind of Business In	erican
2	nin 72 ne. .han "	omp	(Specify only highest grade completed) (Given Elementary/Seconday (0-12) College (1-4 or 5+)	e kind of work done during most of won DO NOT use retired)	king		
2	d with Hygier ther t	Be C	12th Hor 17. Father's Name (First, Middle, Last)	me Health Aide		Private Ho	mes
Maryland 21215-0036	be file ental l ked o ic eve	To	James Artis		ne (First, Middle, Ma	_	
ary	hould and M is mar	7 59		ling Address (Street and Number or Rui	tt Whitle ral Route Number, C		Code)
Σ	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Downing St., N.E.			0018
ore	a, 0 4- 1-			ematory`or other place) 10/4	Date 21	0c. Location - City or To	
Baltimore,	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify) Chesapeal	ce Crematory, Inc.	,,,	Beltsvi.	lle,Md.
Ra	permit. Departr Importa any inji		1) any of () and	22. Name and Address of Facility Henry S. Washi	ngton & S	ons Co.,In	c.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart fallure. List only one cause on each line.	1925 Burroughs Ave ter the mode of dying, such as cardiac	or respiratory arrest	snington, p	Approximate
Lice	Physician/		Immediate Cause (Final disease or condition and Tleaseuting in death)	al Infarction			Interval Between Onset and Death
تجريب	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	it miarculon			
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	ted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or linjury				
	execu an and rial-tra		that initiated events c. Due to (or as a consequence of):				
2	ding Prysician: The law requires that the death certificate be executed the contition of the state of the state of the state of the state of the state of the state of the state of the state of the burial-transit funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d				
20 X 08 / C	artifica ding pl	/Me	IF FEMALE:				
× o	attence for us	cian	23b. Was decedent pregnant in the past 12 morths? 1 ☐ Live Birth 2 ☐ Fetal death 3 1 ☐ Ves 2 ☐ Vo 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ery Day Year
ם :	the de by the ached	hysi	9 Unknown 9 Unknown				
Σ	s that gned b	בַּ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
χ̈́ .	equire	ted	Dilated Cardiomyopathy		1 🗆 Yes	2 No 3 Prol	oably 4 Unknown
Records,	has b	Completed	Morbid Obesity		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
֓֞֞֟֞֜֞֝֞֝֞֝֞֝֞֝֞֝֞֞֝֞֩֞֩֞֩֞֞֩֞֩֞֩֞֩֞֩֓֓֓֓֞֩	n: Ine ficate or, pag		25. Was case referred to medical			d? death? No 1 Yes	2 🗆 No
ומ	ysicia s certi directo	To Be	examiner? 1 Yes 2 DNo Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Chec		0 0 0 0 0 0	,
5 3	ng Pn ter thi		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury		28d. Describe how	e 6 Other (Specify injury occurred	,
	tendir death. for: Af the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No			
2	or Att	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
ָ ֪֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֞֝֓֞֞֞֝֓֞֞֞֝֓֞֝֓֡	To the hospital of Attending Prlysician: The law requires that the death certificate be executed within 24 hours after death a star death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, ar	d due to the cause(s) and manner as state	d,
1	ine no nin 24 ihe Fu helete		only one 3 Cert vin J Nurs a ractioner: To the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and/or investoring the last of examination and or e	stigation in my opinion, death occurred a	the time date and r	lace and due to the car	ise(s) and manner stated
ļ	With Con		29b. Signature and title of certifier	29c. License number		. Date signed (Month, L 09/28/10	Day, Year)
	•		JUL Ton	D67589		U3/ 20/ 1U	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Harold V. Lawson, M.D. 1500 Fore		on Consider	M13-0	10010
	State	_	81. Date filed (Month, Day, Year) 32. Registrar's Simature • •	ar gren rodu, SIIVe	T Spring	Maryland 2	0910
	Registra	r	OCT 0 1 2010 Sener D. gares				

32255

3. Time of Death

Reg. 2.0

2. Date of Death

	/Medi		Nick A. Giannari						SEPT		2010	10:10 AM
	Examir		4a. Facility Name (If not institution, give					4b. City, Town, or L	ocation of Death		y of Death	
			19715 Meadowbrook	Rd.				Hagersto				County
	Funeral Director		5. Social Security Number 6. Sec. 186-30-5714 Usual Residence of Decedent	ex 7. Ag XIM 2□ F	ge (In yrs. last b 76	Yrs. If Und Month	der 1 Year s Days		8. Date of Bird (Month, Da May 27		9. Birthpl Count Gree	lace (State or Foreign try)
	land ow		10a. State 10b. County		10c. City, Tox	vn or Location					11	Od. Inside City Limits
	Mary 4 sh	Ö	Maryland Washingto	n County	Hagers	stown						1 ☐ Yes 2 🎇 No
	the 28a	9	10e. Street and Number	ni codirey	nager	T	Zip Code			10g. Citizen of	What Coun	trv?
	With Page 1	Ö	19715 Meadowbrook	r Rd			21742			U.S.		•
	Jeath 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U,S.			Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		ce - America	
0	ours after death with the Manylan al', or items 23a or 28a-f show Examiner must be notified at	Ē	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ∑Yes 2 ☐ I	No				Rican, etc.)	Bia	ack, White,	
02	al', c	ð	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	1958 - 1962	1 ☐ Yes	2LX No	Specify:		Speci	<i>ty:</i> Whi	Lte
Maryland 21215-0020	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Macical Evaminar must be notified at	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	doation	5+)		sual Occup work done use retire	pation during most of work od)	king	16b. Kind of E		dustry
22	filed v Hygie ther t		17 Fathor's Name (First Middle Last)	3	Ot	mer		18. Mother's Nam	o /Eiret Middle	Restau		
ano	ed at a	Be	17. Father's Name (First, Middle, Last)									
Ž	2 should and Men Is marke aumatic	2	Apostolos Giannar 19a. Informant's Name/Relationship (T		40	b. Matilian Addis	(Ct	Maria Pa	panicho	laou Gi	annar	is
Ma	d2s than 7 Isr traus		Tina Kanelakis Gi									
á	s 1 an f Heal fem 2 other		20a. Method of Disposition	.alilial15-w	20b. Place	of Disposition (A	lame of	brook Rd.	Date	20c. Location		
Baltimore	Pages nent of I nt: If ite		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			ery, crematory o			10 1 00		-	
∄			21. Signature of Funeral Service Licens		Rose i	Hill Cen	leter	y ass of Facility	10-1-20	TO Hage	rstow	n, MD
Ba	pemit. Departn Imports any inju		N-11 71	Ĩ	1 -	1 2 2 1	E	ess of Facility Do	uglas A	. Flery	Fune	ral Home
			Nattin July	aroni 5	Sules			ern Blvd.			own,	
	Di dida		23a. Part i. Enter the disease or composhock, or heart failure. List only of	ne cause on each li	ne.	not enter the m	ode or dyr	ng, such as cardiac	or respiratory ai	rrest,	1	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition	Darke	afan.	1)160	Ase				-	5 Years
	Examiner		resulting in death)	a parku	Due to (or as a	consequence o	f):	,				ed Han C
	קָּיָּ עַ	iner	-1	, (e)	ronar	4 ar	Leri	desea	ese		7	10 years
	and I-trans	Examiner	Sequentially list conditions,	Y	Due to (or as a	onsequence o	1/1/4					5 Na 0
60,	be ey		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	c. <i>)</i>	mel	3 me	lull	5			7	5 fears
687	ficate p phys is the	Pg	resulting in death) Last	D	Due to (or as a	consequence of): /	0.00			-	Jean 1
Box 68760,	death certificate be executed the attending physician and ad for use as the burial-transit	nysician/Medical		d. //	apina	Tary	fler	ewe			/ -	jeurs
	o o	sicis	Part II. Othar significant conditions co	ntributing to death b	ut not resulting	in the underlying	g cause gi	ven in Part I.	23b. Did	tobacco use co	ontributa to	tha causa of death?
P.0		Phy	Vout later	- Denon	But				10	Yas 2□ No	3 Prob	oably 4 ☐ Unknown
ý.	es the ignec be de	þ	y cacaryrs	nyaca								
ord	The law requires that thate has been signed by page 2 should be detac	Completed	Ventelator Musele	By (Ta	To Nou				24a. Was perfo	an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause
ec	law r nasbo e 2 st	n Pie				1	1.0				of c	death?
=		S	E ENE Br	OVARCU	lai	Heel	veu	J	1 🗆 '	Yes 2⊡No	1[Yes 2□ No
Vita	Physician: r this certific aral director,	Be	25. Was case referred to medical exeminer?	Hospital:			0	26. Place of Dea	th (Check only o	one)		
o		. To	1 Yes 2 No			utpatient 3	JOA		ome 5 Resid			()
E	ttending Phy death. :tor: Atter thii / the funeral (lo!	1 ☑Natural 5 ☐ Pending	28a. Date of Inju- (Month, Da)	y Year)	Time of Injury M	28c. Inju Wo	rk?]Yes 2□No	28d. Describe I	now injury occu	TIEG	
isi	Attending ir death. ector: Afte by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	uov - At homo f			1 163 2 110	28f Location (Street and Num	her or Rura	l Route Number,
Division of Vital Records,	after Direct	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	ami, street, ract	ory, office		City or Tov		50, 0, 1.5,4	, rigate riamber,
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edical C		sician: To the best of iner: On the basis of and manner sta	examination a							
	To the within 2 To the Comple	Me	29b. Signature and title of certifier	4		2		se number		29d. Date sign		
			> SAMUEL CA	5AN			1)36	655		sepi-	78	2010
ふか	H 11+1		30, Name and address of person who co	ompleted cause of d	eath (Item 23a)	(Type, Print)	200 .	theers	trun,	MD 3	1740	,
	Sta		31. Date filed (Month, Sau Year)		ar's Signature	4 4		1				
	Registr	ar	JEF 3 ()	WHU King	was &	. par						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day David N. Gaston September Medical 1640 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince Georges Hospital Prince Georges Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs 8. Date of Birth
(Month, Day, Year
Dec. 17, 1 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Hours Min. Country)
Wasn. Director Yrs 77-78-9383 53 956 , DC Usual Residence of Decedent 10a. State within 72 hours after death with the Maryland Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No DC Washington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1504 V St., SE United States 20020 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 x No Specify Completed 3 Divorced Black the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, during most of working Ith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Private 10 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt.
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Allen Leola Morris Gaston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6820 Brentwood Drive
Upper Marlboro, MD 20772 Jeffrey Gaston/brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Marlboro, 10/8/10 Park 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Landover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Brain Metastasis Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Liver Metastasis resulting in death) Last Due to (or as a consequence of attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day signed by the a 2 🗌 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

Hospital

and address of person who completed cause of death (Item 23a) (Type, Print)

perbatch, 3001

			4	partment of Health and Me ertificate of Death	ental Hygie Reg.	2010 32257
	Physici		Decedent's Name (First, Middle, Last) Boyd John Goff		2. Date of Death	3. Time of Death
The state of	/Medic Examir		4a. Facility Name (If not institution, give street and number) 17501 Bowie Mill Road	4b. City, Town, or Location of Death Derwood		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 565-50-8249 G. Sex 1 M 2 F 7. Age (In yrs. last birthda 70 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 8 19	939 Sirthplace (State or Foreign Country) Minnesota
	Maryland I-f show	tor	10a. State 10b. County 10c. City, Town or	_ocation WOOd		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	I Director	10e. Street and Number 17501 Bowie Mill Road	10f. Zip Code 20855	10g.	Citizen of What Country? United States
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinational by notified al	d by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1	. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Pueric R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	12 should be filed within 72 h n and Mental Hygiene. 7 is marked other than "natu fraumatic event, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Gingle (1-4or 5+) College (1-4or 5+) 4 Fi	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) nancial Analyst	Ţ	. Kind of Business/Industry J. S. Government
Maryland	nuid be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) John Boyd Goff	18. Mother's Name (Virginia		eal
	ind 2 sho alth and 27 is me er traume			ling Address (Street and Number or Rural 01 Bowie Mill Road,		*
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		I Burial 2 Cremation 3 Memoval from State	position (Name of Paratory or other place) litan Crem. 9/27		Location - City or Town, State
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	Name and Address of Facility Muriel H. Barber P. O. Box 5038, I		
	Physician /Medical Examiner	er.	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart faintle. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chondrosarco a. Chondrosarco bue to (or as a consequence of): Sequentially list conditions,		respiratory arrest,	Approximate Interval Between Onset and Death 4 months
8760,	cate be executed physician and the burial-transit	dical Examiner	days, (bleam git immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Custo (or as a consequence of): Due to (or as a consequence of):			
.O. Box 6	death certifine attending point of for use as	Physician/Medical		□Ectopic přegnancy □ Other (s <i>pecify</i>)		23d. Date of delivery Month Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ŒUnknown
Il Reco		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
of Vita	Attending Physician: The la r death. ector: After this certificate has by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	of 28c. Injury at 28		
Division of Vital Record	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	1 ★ Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 4 Homicide determined (Month, Day Year) Injury 28e. Place of Injury - At home, farm, so building, etc. (Specify)	Work? M 1 □ Yes 2 □ No treet, factory, office 28	If. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	e Hospital or 24 hours afte e Funeraf Dir etely filled in I	edical C	29a. Certifier (Check only one) 16 Certifying Physician: To the best of my knowledge, deadless of examination and/or and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	a(s) and manner as stated. and place, and due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier More de Homo	29c. License number G 39666		Date signed (Month, Day, Year) September 27, 2010
2	STIVA		30. Name and address of person who completed cause of death (Item 23a) (Type Randall J. Meredith, M.D. 10 31. Date filed (Month, Day, Year) 32. Registra's Signature	6 Garden Gulch, We	averville	e, CA. 96093
	Sta Registr	X1	SEP 28 2010 Description	Lacked		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 2010 3:10 P M Audrea Hillyard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery <u>Silver Spring</u> Social Security Number 9. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) 08/13/1930 Days 1 - M 2 X F **Director** Yrs. 577-36-7891 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 28a-f 1X Yes 2 ☐ No MDMontgomery Silver Spring 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20906 14211 Peartree Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ō δ 1 Never Married 2 Married ☐ Yes 2 🖾 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 X Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic avant". (Specify only highest grade completed) Montgomery County Public Schools Elementary/Seconday (0-12) College (1-4 or 5+) 12 Personnel Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Hillyard Theresa Ertl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Gue - Son 13413 Yorktown Drive Bowie, MD 20715 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 09/28/2010 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Your Mentgoney Meathan 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or compil vitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisi only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Perforated Diverticulum of Sigmoid Colon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Peritonitis Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: use as the burial-transit End Stage Emphysema that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Septic Shock, Respiratory Failure, Abdominal Aortic 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? Aneurysm, Heavy Smoking 24a. Was an has performed? Yes 2 N 2 🗌 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🔀 No ٩ 1 K Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this illed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after determined To the Hospital within 24 hours a To the Funeral C Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination almost investigation, in my opinion, south of the destroy of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Aupanich.

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item / per FH G909 11/4/10 dka
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2010 32259 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28 2037 Donald Lee Grunden 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Memorial Talbot Easton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔲 M 2 🗆 F Days Hours 7 /26 / 1931 Country) 79 Director Yrs PA 175-24-8930 Usual Residence of Deceden 28a-f shov with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No PA Bairdford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25471 Goldsboro Rd Henderson 21640 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Il Hygiene. other than "natural", or i 1 Never Married 2 Married Grunden Š Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Custodian A. Count Librarys Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Glenn Grunden Garnet Beryl Grunden Donald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Grunden Goldsboro Road, Henderson, MD 21640 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Chesapeake Crematory 9/30/2010 4 Donation 5 Other (Specify) Chester, MD 22. Name and Address of Facility Fleegle and Helfenbein Funeral 21. Signature of Juneral Service Licensee any in Home, 106 W. Ave., Greensboro, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Due to (or as a cons. guence of) Medical resulting in death) Examiner neumonla Sequentially list conditions Examine Due to jurias a consequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical # 7+ #9 (200) I'M Co. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No 1 Tes Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ၉ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death. To the Funeral Director: Af Investigation Could not be 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the buood
3 Certifying Nurse Fractioner: Te only one 29b. Signature and title of certifu mi) Saterber 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Cynwood Dr., Easton MD 21601 M.D anton 31. Date filed (Month, Day . Registrar's Signa State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State of		artment of Health a <i>tificate of Death</i>		ene g. No. 2 0 1 0	32260
Physic	ian/	1. Decedent's Name (First, Middle, Last) Joanne Elizabeth H.			2. Date of Death Month Sept. 2	8 ^{Day} 2010 ear	3. Time of Death
Med Exam		4a. Facility Name (if not institution, give street and num		4b. City, Town, or Location of		4c. County of Death	2:00 p. M
		Loyalton of Hagerstown 5. Social Security Number 6. Sex	7 A	Hagerstown		Washingto	
Funera Directo		217-58-9806 1 □ M 2 🖾 F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye	g. Birthp Co <i>unt</i> 1952 Mary	lace (State or Foreign ry) Land
and show at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		11	0d. Inside City Limits
Maryle 28a-f s	irect	Maryland Washington	Hager	stown			1 ☐ Yes 2 🛣 No
with the 23a or sst be n	Funeral Director	10e. Street and Number 20009 Rosebank Way		10f. Zip Code 21742	109	g. Citizen of What Coun	try?
faryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ھا	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	rces?	Nas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, I Yes 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - America Black, White, e	etc.
hours a	leted	3 Widowed 4 X Divorced Year or Da	ites.	dent's Usual Occupation	16	Specify: whi	
Maryland 21215-0036 2 should be filed within 72 hours affer th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-12)	-4 or 5+) (Give I	kind of work done during most of NOT use retired) emaker	of working	her own ho	
nd 2	Be	17. Father's Name (First, Middle, Last)			's Name (First, Middle, Mai		ome
Ylar	욘	Roger H. Schutte			Teresa Trace	y Regester	
Na 2 sh 1th an 27 is		19a. Informant's Name/Relationship (Type, Print) Diane Leimbach - sister		g Address (Street and Number Apple Court, S	,		,
Baltimore, I permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from	Otato	natory or other place)		Oc. Location - City or To	wn, State
Baltimo permit. Page Department of Important: If any injury or		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice/see		n Crematory 9 Name and Address of Facility		agerstown,	Maryland
Dep Dep and B		1 Jadinin	11	I5 E. Wilson Bl			21740
Physician	_	Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	aused the death. Do not ente ch line.	er the mode of dying, such as ca	ardiac or respiratory arrest,		Approximate Interval Between Onset and Death
Medica Examine	-	Mal	or as a consequence of):	luna CA	RCINOMA	-	
p iti	Examiner	Sequentially list conditions, if any local cause. Enter Underlying Cause (Disease or linjury	o as a consequence of):		1		
roate be executed in the punal-transit is the bunal-transit	Exar	that initiated events c	or as a consequence of):				
/60 cate be physicial	edical	d					
DIVISION OT VITAI RECORDS, P.O. BOX 08/ To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the attending t completed filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
that the med by e detac	by Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
rdS, equires een sig nould b					1 X Yes		ably 4 🗌 Unknown
Kecords, The law requires cate has been sig, page 2 should b	Completed				24a. Was an autopsy performe 1 \(\text{Yes} \) 2	prior to con death?	sy findings available inpletion of cause of
VITAI iysician is certifii director	To Be	25. Was case referred to medical examiner? 1 Yes	Inpatient 2 ER/Outpatien	26. Place of Death Other:	(Check only one) sing Home 5 Residence	on 6 Other (Specify)	
on or anding Phy ath.		27. Manner of Death 28a. Date of		28c. Injury at work? M 1 Yes 2 N	28d. Describe how i		
DIVISION is all or Attendii s's after death.	l Certificate:	3 Suicide 6 Could not be	of Injury - At home, farm, stre g, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural I tate)	Route Number,
the Hospit in 24 hour the Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the be 2 Medical Examiner: On the basi 3 Certifying Nurse Practioner: T	s of examination and/or investi	gation, in my opinion, death occu	urred at the time, date and p	place, and due to the caus	se(s) and manner stated.
To t With		29b. Signature and title of certifier	M	29c. License number	12 - Md 29d	Date signed (Month, D	ay, Year)
19H-4		30. Name and address of person who completed cause		ersburg Pike	Hagerstown	1MD 217	42
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature	Sal	J		

			State of Maryland /				and M	ental Hy	giene 2 n	10	32261
			Registrar 1. Decedent's Name (First, Middle, Last)	Ceri	tificate of D	veatn		2. Date of Dea	Reg. No.	. 0	т
	Physicia Medio		Lauraine Huber						er ^{Da} Ž8,	2010	3. Time of Death 3:15 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) Calvert Manor Health Care		4b. City, Town, or Rising		f Death		4c. County Ceci		
	Funeral		5. Social Security Number 195-14-3094 6. Sex 1 □ M 2 ဩ F 7. Age (In yrs. last b) 88		If Under 1 Year Months Days			8. Date of Birt	h (, Year) 0.2.1		olace (State or Foreign
-	Director		195-14-3094 ¹ □ M ² L¾F 88	Yrs.				Dec. 16	, 1921	Vir	ginia
	land shov d at	후	10a. State 10b. County 10c. City, To							1	0d. Inside City Limits
	Mary 28a-1 otifie	Director	Maryland Cecil North	East							1 🗌 Yes 2 🔀 No
	ith the 3a or t be n		10e. Street and Number		10f. Zip Code				10g. Citizen of V		•
	ems 2	Funeral	10 Lums Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. W	21901 /as Decedent of His	spanic Orig	in? (Spec	ify Yes or No-	United	e - Americ	
36	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	è	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☐ No	If	Yes, specify Cubar ☐ Yes 2 🖾 No	n, Mexican,	Puerto R	lican, etc.)		k, White,	etc.
8	hours natura ical E	letec	3 X Widowed 4 □ Divorced 11 Tes, Silve Year or Dates.		ent's Usual Occupa				16b. Kind of Bu		
212	nin 72 ne. han "r e Med	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki life, DC	ind of work done d NOT use retired)	uring most	of workin	g			custry
2	d with Hygier Ither t	Be C	17. Father's Name (First, Middle, Last)		memaker				Own H		
/Janc	should be file n and Mental P 7 is marked o raumatic eve	70 E	David Farmer					(First, Middle, i a Payne	Maiden Surname)	
, Maryland 21215-0036			19a. Informant's Name/Relationship (Type, Print) James W. Huber, Jr.	9b. Mailing	g Address (Street a ms Road)	nd Number North	or Rural	Route Number	; City or Town, S 21901	tate, Zip C	Code)
Baltimore,	Page 1 and 2 ment of Healt ant: If item 2 ury or other i		1 Burial 2 □ Cremation 3 □ Removal from State cemer	tery, crem	sition (Name of atory or other place	e) O(ctob 20	er 2,	20c. Location -	-	
Balti	permit. Page 1 a Department of H Important: If ite any injury or ott		21. Signature of Fuper, service uponsee	22.	Name and Address	,	C	1	uneral		
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death) a. Hule 1 Due to (or as a consequence		v De	m	en	tra		+	Onset and Death
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	uted d ansit	Examiner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or linjury	i Oi).							
	cate be executed physician and the burial-transit	al Ex	that initiated events c. Due to (or as a consequence)	of):							
760	cate be physic s the b	edical	d							\pm	
BOX 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hourst start death. within 24 hourst blirector. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)	/			23d. Dat	e of delive	ery Day Year
л. Э	that th	y Ph	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.		23e. Did to	bacco use contri	ibute to th	e cause of death?
ds,	equires en sig	ted t						1 □ Y	es 2 No	3 🗌 Prob	oably 4 🗆 Unknown
vitai Records,	ician: The law re certificate has be rector, page 2 shr	Completed by						24a. Was a autopoperfor	sy p med? d	rior to cor leath?	osy findings available mpletion of cause of
<u>0</u>	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?		26. Pla	ce of Death	(Check o		2,2010	163	22 NO
>	Physion this caldire	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C			4 Nur			ence 6 Othe		
VISION OF	ending lath. eath. er. After e funer	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ AccidentInvestigation	Time of injury	28c. Injury work? M 1 🗆 Y	at ∕es 2□n		3d. Describe ho	ow injury occurre	d	
DINISI	tal or Atter safter de al Directo ed in by the		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, stree	et, factory, office		28	3f. Location (St City or Town	reet and Numbe n, State)	r or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my knowledge of the basis of examination and only one)	or investig	gation, in my opinion	i, death occ	urred at the	ne time, date an	d place, and due	to the cau	ise(s) and manner stated.
	Voit To 1		29b. Signature and five of certifier	M	29c. License		36	449	29d. Date signed	(Month, E	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) Dr. Gloria Simonson 133 N. B	ridge	e St. El	Lkton,	, MD	21921			
	State Registra		31. Date filed (Month, Day, Year) OCT 01 2010 32. Registrar's Signature	are	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
aded #8 per FH, RG FCHD 10/6/110 at a f Death

			1 - For State Amended #8	State of Ma per FH, RG	FCHD 10	epartment of Certificate of	Death		ene .g. No. 2011	32262
	Physicia	n/	1. Decedent's Name (First, Middle	e, Last)	_			2. Date of Death Month	1	3. Time of Death
and the	Medic	cal	Karen S. Hugh					Septembe	er 26 201	0 4:00a ^M
	Examir	ier	4a. Facility Name (if not institution Gilchrist Hosp				or Location of Deat	h	4c. County of Dea	
	Funeral	Г	5. Social Security Number	6. Sex 7. Age	e (In yrs. last birth	day) If Under 1 Yea		De Date of Birth	Balti	rthplace (State or Foreign
	Director		214-70-4281	1 □ M 2 🔀 F	55 Y	rs. Months Days	Hours Min.	Dec. 13,	2010 M	aryland
	and show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryla 28a-f	Director	Maryland Howan	rd.	Woodbi	ne				1 ☐ Yes 2 🛣 No
	h the		10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	ountry?
	th wit ms 23 must	Funeral	2676 Jennings (797		United St	ates
က္	er dea or ite niner	by Fu	11. Marital Status 1 ☐ Never Married 2 🔀 Marr	12. Was Decedent E Armed Forces? 1 Yes 2 1		 Was Decedent of If Yes, specify Cut 	Hispanic Origin? (Sp pan, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
903	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	.,,	1 ☐ Yes 2 🛛 N	o Specify:		Specify:	White
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pu	filed val Hyg	Be C	17. Father's Name (First, Middle, L	ast)			1	me (First, Middle, Ma		Oire
yla	uld be I Ment narke natic (욘	William Paul Wr				Joan S.	Lockwood		
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ē,	f Heal f Heal item 2		John D. Hughes 20a. Method of Disposition	/ Husband	20b. Place of i	Disposition (Name of			dbine, Ma Oc. Location - City o	ryland 21797 Town, State
mo	Page nent o ant: If Iry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1	crematory or other pla haels Ceme	- 1	,	It. Airy,	,
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		21. Signature Funeral Service L	ensee ///////	1/				ordel Ma	ryland 21702
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ord	/ requi	lete						24a. Was an		topsy findings available
3ec	Physician; The law this certificate has al director, page 2	Completed						autopsy perform	prior to death?	completion of cause of
<u>a</u>	sian; T ertifica ctor, p		25. Was case referred to medical examiner?			26. F	lace of Death (Chec	1 L Yes 2	NO TE YE	s 2 🗆 No
⋛	Physic this or	၉	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier 28a. Date of injury		patient 3 DOA Oth	4 ☐ Nursing H		ce 6 Other (Spec	ity) Hospice
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isio	Atter er dea ector by the	iji	3 Suicide 6 Could n	ot be 28e. Place of Injur		n, street, factory, office	. 100 22110		et and Number or Ru	ral Route Number,
<u>≥</u>	ital or ral Dir lled in			building, etc.				City or Town, S		
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 \(\subseteq Medical Ex	Physician: To the best of m caminer: On the basis of exc Nurse Practioner: To the b	amination and/or i	nvestigation, in my opini	on, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
_	Within Complete Compl		29b. Signature and title of certifier)	29c. Licens	e number		d. Date signed (Monti	
			1 14		4)		1139	,	September	27, 2010
	13		30. Name and address of person w Clement Knight				G020 Co1-	umbia Ma	walend 210	74.4
	State	e	31. Date filed (Month, Day, Year)	32. Registrar	'e Signature		3020 0011	ишота, ма	ilang 710	J44
	Registra	r	SEL >	O ZULU LEV	win p	facked.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Brent Octavious Hector Medical September 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George Hospital PG Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 08/20/1976 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X**XM 2 □ F Days Min. Hours Country) Director 579-02-3139 34 Washington, DC Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho. must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits MD PG Largo 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 182 Green Meadow Way apt#P 20774 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or iter the Medical Examiner Black, White, etc. þ XX Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BA IT Specialist Private Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Otis Hector Brenda Crockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 Brenda Cotton/ Mother 2246 Brightseat Road#201; Landover, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2010 Harmony Mem PK Landover, MD 21. Signa Lip of Funeral/Service Lips 22. Name and Address of Facility Freeman Funeral Svcs Road; Temple Hills, Part I. Enter the disease of shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ≠only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner RISIO Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown signed by the aid be detached for 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Vunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🔲 Yes 2 No Other: 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident completed filled in by the Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one) 3 ertifying Nurse Practioner: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifie

Registrar
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State

30. Name and address of person who

31. Date filed (Month, Day, Year

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23a) (Type, Print)

cause of death (Item

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Marie Heitmuller Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbo astor Social Security Numbe 7. Age (In vrs. last birthdav Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months March 22. Year 1919 Director 212-16-1020 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Caroline Denton 1 TyYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 322 South Second Street 21629 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 □ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Manager Staff Management Services (Specify only highest grade completed) Elementary/Seconday (0-12), 11 H.S. Grad College (1-4 or 5+) Electric Company Maryland 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Surendorf Catherine Elizabeth Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas S. Chambers/Son 322 South Second Street, Denton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery Sept. 28, 2010 Denton, Maryland 21. Signature of Funeral Service Lice Moore Funeral Home, P.A. <u> 2162</u>9 South Street, Denton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of spiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg 1 Yes 2 1 9 Unknown Day 5 Other (specify) Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires to hours after death. Funeral Director; After this certificate has been sign No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred edical Be 26. Place of Death (Check only one) Hospital: 1 Tyes Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident 3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Coptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and to contifier 30. Name and addre Stephen Will State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 26, 2010 **Physician** Charles Arthur Jones 1:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2710 Keystone Lane Prince George's Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 472-32-6964 Director 4/13/1934 76 Minnesota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modral Experiment is not be in affiled at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Directo MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2710 Keystone Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korean W Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No Specify: þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coordinator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Jones Florence Plein ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Jones / Spouse 2710 Keystone Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9/28/2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death pancreatic cancer Immediate Cause (Final **Physician** o WUS. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 9 2 7 2 0 1 0 29b. Signature and fifte of certifier 29c. License number D19838 elouly, u.D. Bestyate Rd. Annapolis, U.d. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart F. Selouick, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 8 2010 Registrar

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Registrar

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32. Registrar's Signature

		Please	Type or Print in I						_	
	1	For State Registrar	State of Marylan		tificate of L			Reg. No		32268
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Funeral		5. Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	y, Year)	g. Birt Cou	hplace (State or Foreign untry)
Director	- 1	Usual Residence of Decedent					Loct. 2	5, 1	1932l M	aryland
28a-f sho	lecto	Maryland Anne Ar		y, Town or Lo		nnapolis				10d. Inside City Limits 1 ☐ Yes 2X No
is 23a or nust be n	Jerai L	10e. Street and Number 2709 Riva Road			10f. Zip Code	21401		10g. Ci	tizen of What Co	
amin 1	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates.	1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2★★No	n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: W	
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ked other ic event, th	ao I	12 17. Father's Name (First, Middle, Last) Peter A. Macalus	0	Derit	or beput	18. Mother's Nan	ne (First, Middle,	Maiden	Surname)	Appears
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nent of He ant: If item ary or othe		20a. Method of Disposition **Disposition** **Dispositio	Removal from State	emetery, cren	sition (Name of natory or other place		Date /1/2010		ocation - City or	
Departin Importa any inju		21. Signature of Funeral Service Acens	E Will		Name and Addres					al Home , MD 21401
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and I-transit		Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury								
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate. To Be Completed by Dhysician Medical Evanti	riiysicidii	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★★o 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	l death 3	Ectopic pregnand Other (specify)	У			23d. Date of deli Month	Day Year
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neurs aft neral Dir I filled in	- 4	29a. Certifier 1 ☑ Certifying Phy	building, etc. (Specify,	edge, death o				use(s) ar	nd manner as sta	
the Funeral	- г	(Check 2 ☐ Medical Exam only one) 3 ☐ Certifying Nur	iner: On the basis of examination se Practioner: To the best of my	and/or invest	igation, in my opinio leath occurred at the	on, death occurred a e time, date and pla	at the time, date a ice, and due to the	nd place e cause(s	e, and due to the o s) and manner as	cause(s) and manner stated stated.
To t		29b. Signature and title of certifier		M	29c. License D00	number 063239			te signed (Month tember 2	
9.		30. Name and address of person who				:0 201 E	daarata	- M	awl and	21027

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State Registrar

31. Date filed (Month, Day, Year) SEP 2 8 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar		State	of Mary	land / De/ C	epartmer C <i>ertificat</i>	nt of H e of D	lealth ar <i>Death</i>	nd Me	ental Hy	giene Reg. No	20	10	3226	9
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hours natura dical E	Completed	-	15. Decede	Year or D nt's Education est grade completed			ecedent's Usua			£ ut da .		16b. K	ind of Bus	siness Ind	lustry	_
thin 72 ine. than "	l wo	Elementary/Sec		College (*			ive kind of wo e, DO NOT use	e retired)	uring most of	r working	1					
led wit Hygie other ent, th	Bec	10th 17. Father's Name (i	(First, Middle, I	.ast)		1	Farmer	<u>-</u>	18. Mother's	s Name (First, Middle,	•	rmin Surname)			_
d be fi Mental arked atic ev	은	Joseph	Morris	King					Mat	ude	Smith		,			
shoul h and 7 is m trauma		19a. Informant's Na				19b. N	failing Address	(Street a	nd Number o	or Rural F	Route Numbe	r, City or	Town, Sta	ate, Zip C	ode)	
and 2 Healt tem 2		Cathering 20a. Method of Disp		in/Daught			0 Gardi		Road,	Wal			land			_
Page 1 nent of ant: If i		1 😾 Burial 2 4 🗌 Donation		3 ☐ Removal from Specify)	n State	cemetery,	crematory or o	ther place					1dor:	•		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service I	icense 2			22. Name an	d Addres	s of Facility	Hui	ntt Fu	nera	1 Hor	ne		_
				complications that			3035 01 enter the mod						f, M	D 206	Approximate	_
Physician/		shock, or heal Immediate Cause (disease or condition	(Final	only one cause on ea		Mallit.									Interval Between Onset and Death	
Medical Examiner		resulting in death)		Due to	(or as a cor	Mellitinsequence of):	15									_
	er	Sequentially list co				Artery	Diseas	e								_
uted d ansit	amir	cause. Enter Underlying Cause (Disease or linjury that initiated events c.														
cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last Due to (or as a consequence of):														
cate by physic the b				d										\perp		_
attending p	Physician/M	IF FEMALE: 23b. Was decedent		23c. If yes, ou			3 🗆 Ectopic j	ragnana.	,				23d. Date	of delive	ry	
death	/sicia	in the past 12 r 1 Yes 2 Dunknown	□ No		gnant at time		5 Other (sp		<i>'</i>				Mont	th	Day Year	
hat the ed by t detach	by Ph	Part II. Other signif		ons contributing to a	death but no	ot resulting in t	he underlying	cause give	en in Part I.		23e. Did to	obacco u	ise contrib	oute to the	e cause of death?	_
quires t en sign uld be	ed p										1 🗆	Yes 2	□ No 3	3 🗌 Prob	ably 4 Unknown	I
law rec	Completed										24a. Was autor	osy	pr	ior to con	sy findings available apletion of cause of	
r: The icate h r, page		05.246	- 4 4 4:1									rmed?	de 1	eath?	2 🗌 No	_
/siciar s certil	To Be	25. Was case referred examiner?	No medical	Hospital:	Innatient	2 ☐ EB/Outn	atient 3 🗆 DO	Othe	r:		nly one)	donoo 6	Other	(Specify)		_
ng Phy fter thi		27. Manner of Death	h 5 🗌 Pendir	28a, Date		28b. Tim	e of 2	8c. Injury work?	at		d. Describe h					_
ttendii death. :tor: Ai	Certificate	2 Accident	Investig	gation			М	1 🗆 Y	res 2 🗆 No							_
al or Ai s after I Direc d in by		4 Homicide	determ		ing, etc. (Sp		street, factory	, office		28	f. Location (S City or Tow			or Rural I	Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Medical	(Check 2	🖳 Medical E		sis of examir	nation and/or in	vestigation, in	my opiqior	n, death occur	rred at th	ie time, date a	ind place,	, and due t	to the cau:	se(s) and manner state	ed.
To the within ; To the сотре	Σ	only one) 3 29b. Signature and		Nurse Practioner:	To the best	of my knowled	/	red at the . License		nd place,			and man te signed (_
		1	17	720	W	my		1	D 20	62	9	_	91	28	110	_
72310		30. Name and address George Wa						ldor	f, MD	2060	03		1			
Stat Registra		31. Date filed (Monti		32. F			park									
			DEL 9	U CUIV	VCT- "		11									

rederick Carlto	n Lo		of Maryland	Depa	ırtmen	t of Hea	lth and			gibi	201	0 3227
		1- For State Registrar		Cer	tificate	e of Deat	th			Reg. No.		
Physici Medical Exam			on LONG						2. Date of De Month Septemb	Day er 26,		3. Time of Death 1530 hrs
		4a. Facility Name (if not institution, gi Washington County Hosp					Town, or Lerstown	ocation of [Death		c. County of Dea Washington	th
Funeral Director		5. Social Security Number 6. S 236-40-7893	6ex 7. Age	78 (In yrs. la	ast birthda	Yrs. If Und	ler 1 Year hs Days		Min	,	C	irthplace (State or Foreign country) est Virginia
Þ		Usual Residence of Decedent 10a State 10b. County		10c. City,	Town or I	ocation			•			10d. Inside City Limits
Aaryland 28a-f show any 1 at once,	ō	Maryland Washin	gton	roc. Oity,		erstown	1					1 X Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust he notified at once	Director	10e Street and Number 605 Sunset Avenu	ıe			10f. Zip		.740		10g. Cit	izen of What Co USA	untry?
근 등의	Funeral	11. Marital Status 1 Never Married 2 Married	1 X Yes 2	No		If Yes, speci	ify Cuban,	Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	lo-	White, etc.	erican Indian, Black,
irs afte ural",	l by	3 X Widowed 4 Divorce	or Dates: only highest grade com	9-56	16a. Dec	Yes 2			nd of work done	16b.	Specify: WI Kind of Business	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			ng most of wo						·····
9036 within iene.	mp	8	0		plu	mber					plumbing	3
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	BeC	17. Father's Name (First, Middle, Last William Martin]	•				1		Name (First, Middle garet Has		Surname)	
212 ould be d Ment s mark	To E	19a. Informant's Name/Relationship (19b. M	lailing Address	s (Street		er or Rural Route No		City or Town, Sta	te, Zip Code)
MD and 2 sho alth and m 27 is		Carol Burger - da	aughter	Last					ysville,			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 XBurial 2 Cremation 3		ه امر	rematory	isposition (Nat or other place ew Ceme)		Date /30/2010		Location - City o	
Itim ii. Pag artment ortant:		4 Donation 5 Other Specify 21. Signature of Funeral Service Lice	r: nsee	Fa		22. Name and		-			NERAL HO	47-11
Deprin		Malue B R.	nh:						vd., Hage			
Physician 'Vedical		23a. Part I. Enter the disease, or com failure. List only one cause on e		the death.	Do not er	nter the mode	of dying, s	such as card	diac or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
kaminer	4 1	Immediate Cause (Final disease a or condition resulting in death)	Subdural hema Due to (or as a conse):							Death
	Ļ	Sequentially list conditions, b	-									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause {Lisease or injury that initiated	Due to (or as a conse	quence of	·):							
ansit		events resulting in death) Last	Due to (or as a conse	quence of	·):							
be executed ician and urial - transi	dical	UNPENDED	AMENDED									
8760 ificate l ig phys s the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregr	nancy	Fetal death	3	Ectopic p	regnancy	23	d. Date of delive	ry Day Year
Box 68760, c death certificate be the attending physicid for use as the buried for use a	Physician/Me	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at	time of dea	ath 5	Other (Spe						.,
, P.O. I	Ą	Part II. Other significant conditions Congestive Heart Failure	_	but not re	sulting in	the underlying	g cause gi	ven in Part		_	✓ No 3 Pro	o the cause of death?
Records, The law require ficate has been si	Completed								24a. Wa			autopsy findings available completion of cause of
tal Recc tian: The lar certificate ha		25. Was case referred to medical					00 81			ormed? 2 ✓ N	death?	res 2 No
of Vital ng Physician ther this certi	Be	augustus and	Hospital: 1 / Inpatie	nt 2	ER/Outpa			``	Nursing Home 5	Reside	ence 6 Oth	er:
on of anding Ph.	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day You Sep 26, 2010	ry ear)	28b. Time			y at Work? es 2 ✔ N	28d. Describe Subject fel			-
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Certification:	2 M Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of Inj				, office bu	uilding, etc.	or Town,	State)	and Number or R	Rural Route Number, City
To the Hospi within 24 hou To the Funer completely fil	Medical C	20a Cartifier	ian: To the best of my	knowledg	ge, death o	occurred at the			e, and due to the car	use(s) ar	nd manner as sta	ated.
To with	Mec	298. Signature and title of certifier	and manner stated.				c. License				Date signed (M	
		() wholey	4				O.C.M	1.E.		Sep	ptember 27,	2010
H_ # . 1		90 Name and address of person who Laron Locke MD. Assis	completed cause of ditant Medical Exa		,	enn Street	Raltin	ore MD	21201			
H-3+1	ate	31. Date filed (Month, Day, Year)	32. Registrar		re			- IVID	- 1401			
Regis		OCT 0 1 2	nen A	-		had	,					

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Examiner P.O. Box 68760 of Vital Records,

physician and the burial-transit as t within 24 hours after death.

To the Funerel Director; After thi completely filled in by the funeral Division To the I within 2 To the I

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

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permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examiner must be invitibled at

Physician

/Medical

Examiner

Physician/Medical

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Completed

Be ဥ

Certification:

Medical

29b. Signature and title of certifier

Yuling Zhang

YULING

with the Marylan

V

21215-0036

Maryland

1007

				1 ☐ Yes	2 ☑ No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No Hospita	il: 1 ☑Inpatient 2 ☐ ER/Ou	utpatient 3 DOA	Other: 4 🗆 Nursing I	Home 5 🗆 Residence	6 ☐ Other (Specify)
1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of 28- Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not be 4 Homicide determined 28e	e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, o	office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
(Check only 2 Medical Examiner: O	: To the best of my knowledge on the basis of examination and and manner stated.	e, death occurred a nd/or investigation, i	t the time, date and plac in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)

29c. License number

D70605

29d. Date signed (Month, Day, Year)

September, 24, 2010

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZHANG

9000 FRANKLIN Square DR Balto md 21237 Registrar's Signature

		State of M	laryland / Dep	artment of Hea	alth and M	ental Hyg	iene	0 32272
		- negistrar	Cei	rtificate of Dea	ath	R	eg. No.	0 32212
Physic	ian/	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	-	3. Time of Death
Med	dical	Minie Lopez		T		septembe		
Exam	iner	4a. Facility Name (if not institution, give street and number) Northwest Hospital		4b. City, Town, or Loca	ation of Death		4c. County of	
Funera			e (In yrs. last birthday)		Under 24 Hrs.	0. D-1 (D: 1)	Balt:	- V1
Directo		137-34-3150	92 Yrs.			8. Date of Birth (Month, Day, June 8	Year)	Birthplace (State or Foreign Country) New Jersey
	٦.	Usual Residence of Decedent	72			Julie 0,	1910	New Jersey
yland f shc	ļģ	10a. State 10b. County	10c. City, Town or Lo	cation			_	10d. Inside City Limits
Mar 28a-	įį	MD Anne Arundel		Croft	on			1 🗆 Yes 2 🙀 No
th the 3a or t be r	Funeral Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wha	at Country?
ath w	la la	1765 Carry Place	: 110		21114		Jnited St	ates
or ite			I	Vas Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Spec lexican, Puerto R	ify Yes or No- ican, etc.)		American Indian, White, etc.
O36	a be	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	1	☐ Yes 2 🛛 No Sp	pecify:		Specify:	White
21215-0036 within 72 hours after death with the Maryland glene. ler than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at	Completed by	15. Decedent's Education		ent's Usual Occupation			16b. Kind of Busir	ess Industry
21: Din 72 Pe. Han '	Į į	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	life Di	kind of work done during D NOT use retired)	g most of working	3	Tobal Milia of Baoil	oos maastry
d with	BeC		Hor	memaker			Own Ho	ome
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland this and Mental hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)			Mother's Name		aiden Surname)	
Marylance should be file n and Mental I is marked o raumatic eve	1	James Soriano			ucille S			
Ma 2 sho th and 27 is 1		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and N				
and Heal Heal		Ray M. Lopez / Son 20a. Method of Disposition	20b. Place of Dispos	Petersburg				
Baltimore, bernit. Page 1 and Department of Hea mportant: If item my injury or other		1 D Burial 2 Cremation 3 Removal from State	cemetery, crem	natory or other place)	Da		20c. Location - Cit	
nit. Partme		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Lakemont	Mem'l Gdns	1 09/24	1/20101	Davidson	ville, MD
Baltimore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		Alakit		Name and Address of F				
		23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente	r the mode of dying, suc	ch as cardiac or	respiratory arres		Approximate
Ph sician	,	Immediate Cause /Final				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-,	Interval Between Onset and Death
Medica		resulting in death)	a consequence of):					
Examine								
-	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	t consequence of).					12
cuted nd ransi	Examine	Cause (Disease or linjury that initiated events c.						
e exe	宣	resulting in death) Last Due to (or as a	consequence of):					
routicate be executed physician and sthe burial-transit	edical	d						
oo/ ertific ding p		IF FEMALE:	of programe.					-
Division of vital necords, F.O. box 08/15 the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months:	2 🗌 Fetal death 3 🔲				23d. Date of Month	1
the de	ysi	1 ☐ Yes 2 M2 No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death 5 🗆	Other (specify)			World	Day Year
that the led by the detach	by P	Part II. Other significant conditions contributing to death but	it not resulting in the un	derlying cause given in l	Part I.	23e. Did toba	cco use contribut	e to the cause of death?
Lires 1	g p					ľ		Probably 4 Unknown
The law requires ate has been sig	Completed					24a. Was an		autopsy findings available
he lav te has age 2	l mo					autopsy performe	ed prior death	to completion of cause of
an: T tiffica tor, p	اه	25. Was case referred to medical		26. Place of	f Death (Check or	1 Yes 2	☑No 1 ☐	Yes 2 No
VICAI nysician: nis certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatient				ce a dothair	patient hospice
ng Ph fter th		27. Manner of Death 28a. Date of injur 1 Natural 5 Pending (Month, Day,	28b. Time of	28c. Injury at work?			injury occurred	Jecny)
Attendir r death. ector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes	2 🗆 No			
or At or At after of Direct in by	Sert	4 Homicide determined 28e. Place of Injur	y - At home, farm, stree (Spec <i>ify)</i>	et, factory, office	28	Location (Stree		Rural Route Number,
Durs ours of filled		00-0-10-10-10-10-10-10-10-10-10-10-10-10					,	
24 hr 24 hr Fun eted	Medical	29a. Certifier 1 Certifying Physician: To the best of m	amination and/or investig	iation, in my opinion, deat	ath occurred at the	time date and	place and due to t	o ocupo(a) and manner stated
fo the vithin fo the	Σ	Only one) 3 Li Certifying Nurse Practioner: to the b	est of mv knowledge, de	ath occurred at the time.	date and place a	and due to the ca	uce(c) and manner	an atatad
		► Mskajapalne M.D.		D00574	465	290	d. Date signed (Mo	O Day, rear)
SH		30. Name and address of person who completed cause of de-	ath (Item 23a) (Tvpe. Pri	nt)	2			
~ 6		29b. Signature and title of certifier MSRAPARMENT D 30. Name and address of person who completed cause of de. N. S. Ruj Aparks (M.D. 783) 31. Date filed (Month, Day, Year) SEP 2 8 2010 32. Registrar	5 Smin Av	2.503	Baltima	re, M.	0.2120	7
Sta	te	31. Date filed (Month, Day, Year) 32. Rygistrar	's Signature					
Registr	ar	JEF & O ZUIU Sensu	a B. A.	als				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #18 Per FH G908 10/29/10 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 4:16 PM THOMAS L. LANGFORD Sept. 23 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4351 Centennial Road East New Market Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F 218-20-6089 87 Director June 26, 1923 Maryland Usual Residence of Decedent 10a State 10b Count 28a-f show 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Dorchester East New Market 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or a event, the Medical Examinar must be n 4351 Centennial Road 21631 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2√ No Specify: White Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation within 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver G.E.D. Logistics 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Eva Sellers Unknown Kraft Langford 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) law Sally Jane Hessler/Sister-in-4333Centennial Rd., East New Market, MD21631 20b. Place of Disposition (Name of cemetery, crematory or other place)

East New Market Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 10/01/2010 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 □Yes 2 🗆 No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

32. Registrar's

ewmier Day, Year)

DHMH 17 Rev 1/2001

within 2

29d. Date signed (Month, Day, Year)

			State of Maryland / Department		lental Hygie	ne	32275
			Tioglocal	tificate of Death	r	No. UIU	32213
	Physicia		1. Decedent's Name (First, Middle, Last) Kimberly Dawn Marquis		2. Date of Death Month Sept. 28	Day 2010 Year	3. Time of Death 10:47 p.M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			11017 Lincoln Avenue	Hagerstown		Washin	gton
h	Funeral Director		5. Social Security Number 219-84-8670 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. Dec. 10,	ar) 9. Birthi Court 1959 Vi	place (State or Foreign try) rginia
	ow t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	oction		- [.	0d. Inside City Limits
	uylan a-f sh ied a	Director	Maryland Washington Hagerst				1 ☐ Yes 2 ^X No
	or 28,	Dire	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cour	
:	with t	Funeral	11017 Lincoln Avenue	21740		USA	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "naturaly", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 😾 No	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: w 1	
0	hours natur dical	olete	15, Decedent's Education 16a, Decedent	dent's Usual Occupation	16	b. Kind of Business In	dustry
21	nin 72 ne. han " e Med	omp	Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of worki O NOT use retired)	ng	hos arm	hama
121	d with Hygier thert nt, th	Be C	14	emaker	- Cinat Middle Mair	her own	nome
Baltimore, Maryland 21215-0036	l be file lental l- rked o	70 E	17. Father's Name (First, Middle, Last) William Carl Beatty		e (First, Middle, Maid nces Pugh	den Surname)	
lary	should and N is ma auma	1		ng Address (Street and Number or Rura			
≥ ,	ind 2 steatth	١,	•	7 Lincoln Ave., H		<u> </u>	
ore	ge 1a nt of ⊩ : If ite or ot	1	122 Banar 2 El Gremation 6 El nemovarion State	natory or other place)		c. Location - City or To	
Iţi.	iit. Pa artmer ortant injury	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	wn Mem. Park 10/ 2. Name and Address of Facility M		agerstown, NERAL HOME	
Ba	permit Depar Impor any in once,			15 E.Wilson Blvd.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.				Approximate Interval Between
P	กงูรเต่สก	00	Immediate Cause (Final disease or condition	Conser		- 1	Onset and Death
1	Medical Examiner		resulting in death) Due to (or as a consequence of):				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	ate be executed hysician and the burial-transit	Examiner	Lause (Disease or injury that initiated events c. Due to (or as a consequence of):				
0	be ex sician buria	dical					
3760	g phy as the	l edi	<u> </u>				
. Box 687	to the broptial or Attending Prhysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
ls, P.O.	requires that the desibeen signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Division of Vital Records,	rnysician: The law rec r this certificate has bee sral director, page 2 sho	Completed			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of 2 No
tal	cran: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)		
<u> </u>	ral dir	: To	1	nt 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how i	e 6 Other (Specify)
0 0	ath. :: After e fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	280. Describe flow i	njury occurred	
Division	io the hospital or Attention From Within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral completed filled in by the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral control of the funeral c	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strabulding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rura tate)	Route Number,
	Io the Hospital within 24 hours a To the Funeral C completed filled	Medical	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death of the control of	tigation, in my opinion, death occurred at	the time, date and p	lace, and due to the ca	use(s) and manner stated.
	North Con.		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	
			Miland for Muland My	0 91667		9,30.1	U
افی	4-4		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Medoed Chypic.	, these	sohwa	w.
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	and a			

Harrison Colhoun Murray 4a. Facility Name (if not institution, give street and number) South River Nursing & Rehab. Funeral Director Funeral Director Funeral Director MD Anne Arundel 10a. State 10b. County MD Anne Arundel 10c. City, Town or Location MD Anne Arundel 10c. City, Town or Location Harwood 10c. City, Town or Location Harwood 10c. City, Town or Location Harwood 10c. City, Town or Location WD 10c. Street and Number 11d. Zip Code 11d. Zip Code 11d. Zip Code 11d. Marital Status 11d. Marital Sta	g. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 Yes 2 XX No What Country? A - American Indian, k, White, etc. White Isiness Industry Navy
An analysis And a second of Decided North No	of Death e Arundel g. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 Yes 25X No What Country? A - American Indian, k, White, etc. White Isiness Industry
South River Nursing & Rehab. Edgewater Anne 5. Social Security Number 212-38-6895 Usual Residence of Decedent South River Nursing & Rehab. Edgewater Anne 1. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours Min. 2 / 26 / 19 25	g. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 Yes 2KX No What Country? A - American Indian, k, White, etc. White Isiness Industry Navy
Funeral Director 5. Social Security Number 6. Sex XIX M 2 F 7. Age (In yrs, last birthday) 85 Yrs. Usual Residence of Decedent 6. Sex XIX M 2 F 7. Age (In yrs, last birthday) 85 Yrs. 7. Age (In yrs, last birthday) 85 Yrs. 7. Age (In yrs, last birthday) 15 Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month) 16 Agy, Year) 2 / 26 / 1925	MD 10d. Inside City Limits 1 □ Yes 25 No What Country? A - American Indian, k, White, etc. White Isiness Industry Navy
Usual Residence of Decedent	10d. Inside City Limits 1 ☐ Yes 25€ No What Country? A - American Indian, k, White, etc. White Issiness Industry Navy
	1 ☐ Yes 245xNo What Country? A - American Indian, k, White, etc. White Isiness Industry Navy
MD Anne Arundel Harwood 106. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Citizen of W 10g. Zip Code 10g. Zi	what Country? A - American Indian, k, White, etc. White siness Industry Navy
10e. Street and Number 10e. Street and Number 10f. Zip Code 10g. Citizen of W 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Sive Yes or No- If Yes, Sive Yes or No- If Yes, Sive Yes or No- If Yes, Sive Yes or No- If Yes	A - American Indian, k, White, etc. White sisiness Industry Navy
11. Marital Status No. No	e - American Indian, k, White, etc. White ssiness Industry
Armed Forces? Name Forces k, White, etc. White ssiness Industry Navy	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) William Talbott Murray 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Captain 18. Mother's Name (First, Middle, Maiden Surname) Edmonia Colhoun	Navy
Elementary/Seconday (0-12) College (1-4 or 5+) Captain US 1 Figure 1 and 1	
Note of the state)
William Talbott Murray Edmonia Colhoun	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St	
William Murray Brother 1387 Cumberstone Rd. Harwood, MD 20	City or Town, State
	rnie, MD
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service attentions and place of Disposition (Name of cemetery, crematory or other place) 22. Name and Address of Facility Hardesty Funeral 1 23. Ridgely Ave Annanolis MD 21	Home, P.A.
12 Ridgely Ave. Annapolis, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	401 Approximate
shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
Medical resulting in death) a	
Examiner Sequentially list conditions, b.	
if any, leading to immediate Dus to (or as a consequence of).	
Cause (Disease or linjury that initiated events that initiated events c. Due to (or as a consequence of):	
per open of a purpose of a purp	
d. State	
V The part 12 No. 1 No. 2 No.	te of delivery nth Day Year
Vom Po post plants of the past 12 months? 1 Viscosity Viscosi	
Solution and the state of the s	ribute to the cause of death?
\$\frac{\sqrt{\text{9}}}{\text{9}} \frac{\text{1}}{\text{9}} \frac{\text{1}}{\text{1}} \frac{\text{1}}{\text{9}} \frac{\text{1}}{\text{9}} \frac{\text{1}}{\text{1}} \te	3 Probably 4 Unknown
24a. Was an autopsy performed? 1 \(\text{ Yes 2 Johno} \) 1 \(\text{ Yes 2 Johno} \) 1 \(\text{ Yes 2 Johno} \) 1	Were autopsy findings available prior to completion of cause of death?
performed? 1 Ves 2 Non 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Hospital: Death of Death (Check only one)	1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other	er (Specify)
Solution of the property of th	
28d. Describe how injury occurre (Month, Day, Year) 28d. Describe how injury occurre	er or Rural Route Number,
4 Homicide determined building, etc. (Specify)	
29a. Certifier (Check (Check (Check)) 29b. Certifier (Check) 20b. Ce	e to the cause(s) and manner stated.
only one) 3 \(\to \) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and had been cause(s) and ha	d (Month, Day, Year)
(au M1) Dous 3709 Sept	27Th 20110
	1. Bruic MD
State Registrar 31. Date filed (Month, Day, Year) SEP 2 8 2010 32. Registrar's Signature A. Acade	20713

Registrar
DHMH 17 Rev 1/2001

Theandre Antonio Moody State of Maryland / Department of Health and Mental Hygiene 2010 32278 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death September 19, 2010 **Medical Examiner** 1521 hrs Theandre Antonio Moody 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 14100 McMullen Hwy Cumberland Allegany 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Min. Director 219-02-9260 Country Mary land 1 X M 2 F 35 1975 3, Usual Residence of Decedent any 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov Examiner must be notified at once. 1 X Yes 2 No Maryland Prince George's Landover be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7600 Allendale Circle 20785 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Black Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th rmit. Pages 1 and 2 should be filed within ppartment of Health and Mental Hygiene. pportant: If item 27 is marked other th jury or other traumatic event, the Medi none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Moody Julia May 19a. Informant's Name/Relationship (Type, Print) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Moody, Sr. - Father 7600 Allendale Circle Landover, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Oct. 2, Lee's Crematory Clinton, Maryland Donation 5 Other Specify: 2010 22. Name and Address of Facility Signature of Fuheral Service Licenses Stewart Funeral Home, Inc. 4001 Benning Road NE 20019 Washington, DC art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her **Physician** Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician or use as the bunal -UNPENDED ☐ AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Sep 19, 2010 Subject hanged self 1 Natural 1505 hrs 5 Pending 1 Yes 2 V No Director: death. 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be within 24 hours at To the Funeral L or Town, State) 14100 McMullen Hwy, Cumberland, MD determined (Specify) Jail/Penal 4 ___ Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 20, 2010 yelk Strethall, ms 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar Signatu State Registrar

			1 - For State Registrar	State of Marylar		artment of H			Reg. No.) 0 1	32279
	Physic /Medi		1. Decedent's Name (First, Middle, Last Sylvia Renee Ma	rshall				2. Date of De Month Sep 27	Day	Year 0	3. Time of Death
۽ ولم	Examin Funeral Director	ner	4a. Facility Name (If not institution, give 7527 Buchanan S 5. Social Security Number 6. Se 579-06-6187	St. #348		4b. City, Town, or Landover If Under 1 Year Months Days		8. Date of Bir (Month, Da	Pr th y, Year)	9. Birthp	Georges place (State or Foreign pty) nington D
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Prince G		ty, Town or Lo	cation Hills					0d. Inside City Limits
	3a or 28s	ii Director	10e. Street and Number 7527 Buchanan S	st. #348		10f. Zip Code 20784	1		10g. Citize	en of What Cour	ntry?
336	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23a or 28a-f show event. Irs Modical Exaction is at the inclined at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2€ No		pecify Yes or No o Rican, etc.)	- 14	4. Race - Americ Black, White,	etc.
Maryland 21215-0036	within 72 hou ene. than "nature ne Medical E	Completed	15. Decedent's Education (Specify only highest grad	cation	(Give	dent's Usual Occupa kind of work done di DO NOT use retired) erty Man	uring most of wor	king	16b. Kind	of Business/Ind	dustry
land 2	a la b y	To Be Co	17. Father's Name (First, Middle, Last) Gary Smith				18. Mother's Nan Elizabe		Maiden S		1
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Ty Tyra Dowtin- d		-	g Address (Street a					
Baltimore,			20a. Method of Disposition 1 Donation 5 Other (Specify)	20b. F	Place of Dispo	Buchana sition (Name of natory or other place Mem. Pa	1	Date	20c. Loca	ation - City or To	wn, State
Bail	permit. Page Department of Important: If any injury or once.		21. Signatur Att ineral Service Liven	M01576	56.	Name and Address Allen	of Facility town Re	ernal E d,Camp	aith Spr:	n Funei	cal Syc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line. a Z Due to (or as a conseq		er the mode of dying	, such as cardiac	or respiratory ar	rest.		Approximate Interval Between Onset and Death
,00/00	death certificate be executed e attending physician and id for use as the burial-transit	ledicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)	00						
O. DOX 02	death cer e attendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 100 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23	d. Date of delive	ny Day Year
cords, P	quires that the signed by ald be detacl	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	derlying cause giver	n in Part I.		bacco use	_	e cause of death?
ב ב	sician: The law requires that the certificate has been signed by th lirector, page 2 should be detache	Completed						24a. Was autop perior	sy	prior to con death?	osy findings available inpletion of cause of 2 No
VII.	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Po} \)	lospital:	FD/0	04	26. Place of Dea	-00			
	ng ftel	Η,	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28c. Injury a	4 Notaling Hottle 5 Partesidence 6 Hottlei (Spi			")		
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)			City or Tow	n, State)	Number or Rura	
	Hosp 24 hou Fune etely fil	edicai	29a. Certifier Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my opin	e, date and place, nion, death occur	and due to the or red at the time, or	ause(s) ar date and p	nd manner as sta lace, and due to	ated. the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier	empa	Hendru	29c. License	2580			signed (Month, L	
	6		30 Name and address of person who co	1 M A1.	51.20	Annadi	s Rd =	#13 B1/	Wen	bura M	D 20710
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1		,		J, .	- Vine - 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 28b, e.f. per me.g908.10/28/2010dhb
State of Maryland Department of Health and Mental Hygiene

1- State Amend Item 25 per me.g908,10/20/2010dhb
Registrar Certificate of Death
Reg. No. 20 | 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Dora Catherine Olson 09 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick 205 Mina Dr. Middletown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 9 / 2 9 / 1 9 2 4 1 □ M 2 √2 F 144-12-4510 85 **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 205 Mina Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1XXVes 2 \(\sigma\) No \(1945 - \) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Completed 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working federal life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) government administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dora Morris Spain ည George H. Sorby 19a. Informant's Name/Relationship (Type, Print)
Patricia Blackford (Daughter) 19b. Mailing Address (Street and Number or Bural Route Number, City or Jown, State 20639
Patricia Blackford (Daughter) 911 Stephen Reid Rd., Huntingtown, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 9/26/201DMiddletown, Lutheran cemetery Sig Donald B. Middletown, MD 21769 ature of POB 18, plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. Part 1. Enjer the disease, or com sneck, o heart failure. List only o Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INTRACRAMAL HEMODEHAGE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DAYS FAIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months' 1 Yes 2 No Month Day Year cate has been signed by the a page 2 should be detached for 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? 2 🗆 No 2 1 No Yes of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending work Division FALL 4:00p TRUPT 1 Yes Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number City or Town, State) 1400 W. Main Street Middletown, MD determined Apartment building Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 9/23/2010 039444 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen HundemerMD6 25+ BA Ihoma Jahnson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

10-07615	
Juan Oliva	

uan Oliva	Sta 1- For State	ate of Maryland		rtment of tificate of		d Ment	al Hy	giene		20	10	32281
Physician/	Registrar	a,Last)	Cer	uncate or	Dealli		- 2	2. Date of Dee Month			3	3. Time of Death
Medical Examine	Juan Benjamin Oliva								1, 2010			0428 hrs
	4a. Facility Name (if not institution Frederick Memorial Ho		r)	4	b. City, Town, or Frederick	Location of	Death			County of rederick	Death	
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Yes	_	-	8. Date of B	irth (MM/[DD/YYYY)	9. Birth	place (State or E1 Salvador
Director	213-65-4792	1X_M 2_F	46	Yrs.	Months Day	s Hours	Min.	05-22	-196		Cour	
ž.	Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Loceti	n						1	10d. Inside City Limits
d any	Enada	rick	- "	ederick								1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	MD Frede	. ICK	LI	edelica	10f. Zip Code			Т	10g. Citiz	en of Wha	t Countr	ry?
the Mary 2 tiffed	1478 Key Parkwa	y #202			21702				E1 :	Salva	dor	
r death with or items 23 must be no	11. Marital Status	12. Was Deceder			Decedent of His				0-	14. Race - White,		an Indian, 8lack,
r death wi or items cmust be	1 Never Married 2 X Ma		2K No		Yes 2 No							enic
urs afte	45 Decedents Educates (Sec.	or Dates:	empleted)		's Usual Occupa					Specify: I	•	
72 hou "nat al Exa	Elementary/Secondary (0-12)	College (1-4 or		during mo	st of working life	e. DO NOT u	use retire	ed)	Mon	tgome	ry	
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	3rd			Maint	enance					untry	C1	ub
21215-00 uld be filed win Mental Hygien marked other c event, the M								First, Middle,		Surname)		
2121; uld be fil Mental I marked c event,			sin)	19b. Mailing	Address (Stree			on Ari ural Route Nu		ty or Town	State, 2	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmaric event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Jose A. Garcia	•	DIII)	1478	Key Pkwy	y. #20)2 F:					
re, I s I and f Healb ff item ff item	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S		Place of Disposi cremetory or oth	tion (Name of ce er place)	metery,		Date	20c. L	ocation - (City or T	own, State
Page Page nent o	4 Donation 5 Other Sp	_		mily Ce	metery		10-	13-10	E1	Salv	ado	r ,
Baltimore, permit. Pages I at Department of Het Important: If ite	24. Signature of Funeral Service	1 .	0									ne, Inc.
Physician	23a. Part I. Enter the disease, or	complications that suse	d the death.	Do not enter th	47 14th e mode of dying	, such as ca	rdiec or	respiratory at	rest, sho	ck, or hear	1 200	Approximate Interval
/Medical	failure. List only one cause Immediate Cause (Final disease	on each line: Ac	ute Al rdiome	lcohol egalv	Intoxica	ation	Comp	plicate	ed by	y		Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a con										
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60, e be executed ysician and burial - transit ledical Ex	■ UNPENDED	a. x AMENDED 2: 28d pe	3a,27,	28a-f ₂ 1	er me g	908 1	0-18	-10 vt				
760, cate be physici the buri		23c. If yes, outcome	ome of pregr	nancy	7-11 VC				230	d. Date of d		
COX 6876(eath certificate attending phy. for use as the best for incomplete the control of the c	past 12 months?	I Trive pirar	at time of de	ath -	al death 3 ner (Specify)	Ectopic	pregnar	icy		Month	Da	ay Year
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		ons contributing to dea	ath but not re	esulting in the u	nderlying cause	given in Pa	rt I.					ne cause of death?
S, P.C puires that an signed lid be detailed by								1 Y				bly 4 ✓ Unknown
Records, I The law requires fricate has been sig	<u> </u>							auto		pr		empletion of cause of
tal Rection: The certificate ector, page					00.81			1 ✓ Yes	2 N		✓ Yes	2 No
Vital ysician his certi directo		Upanital:	tient 2 🗸	ER/Outpatient		e of Death (Home 5	Reside	nce 6	Other:	
n of Viding Physical After this funeral dir	27 Manner of Death	28a. Date of Ir (Month, Day	njury	28b. Time of I		ury at Work		28d. Describe	how inju	ıry occurre	d d	1
ion tendir eath. lor: A the fu	1 Natural 5 Pend 2 x Accident Inves			fd 3:3	0am ¹□	Yes 2 🕱	No _	subje unkno v		ngesi	ed	arugs
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the cours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted for the completed by F.	3 Suicide 6 Coul	a not be 28e. Place of			t, fectory, office	building, etc	c. :				r or Rura Ke y	al Route Number, City Pkwy.#202
hour lift of	29a Centiler	mined (Specify)		house			- 1	Frede				
Division To the Bospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	(Check only 1 Certifying Pl	nysician: To the best of miner:On the basis of ex	amination a									
A SEE SEE	29b. Signature and title of certifie	and manner state	<u>a.</u>		29c. Licen	se number			29d.	Date signe	d (Mon	th, Day, Year)
	Pamel Auch	all, mis			O.C	.M.E.			Oct	ober 4,	2010	
7	30. Name and adviess of person				1 D- n: 0t	4 D. II.		D 04004			7777	
	Pamela E. Southall, N 31. Date filed (Month, Day, Year)		dical Exa		1 Penn Stree	et, Baltım	ore, M	ש 21201 				
State Registra		SZ. Regist	-	4.1								

enise Ponce	De L	eon Si 1- For State Registrar	ate of Maryla		rtment of tificate of		ına ı	vientai H		Reg. No.		
Physic		Decedent's Name (First, Midd	le,Last)						Oate of Dea Month	ath Day	Year	3. Time of Death 0331 hrs
Medical Exam	nine	Denise Poi 4a. Facility Name (if not institution	nce de Le on, give street and nur		1	4b. City, Town,	or Loc	ation of Death	October 4		County of Deat	
		Southern Maryland H	-	,		Clinton				Pı	rince Georg	e's
Funera Directo		5. Social Security Number		7. Age (In yrs. la		If Under 1 Y Months D	_	If Under 24Hrs. Hours Min.		·	Forei	rthplace (State or gn
		073-56-0175 Usual Residence of Decedent	1 M 2 XF		4.8 Yrs				June	13,	196 <u>4</u> "	ountry) NY
any		10a. State 10b. County		10c. City,	Town or Locati	on						10d. Inside City Limits
Maryland 28a-f show	j 5	MD I	PG	Su	iitlan							1 X Yes 2 No
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizo	en of What Cou	intry?
ith the	a D			dent Ever in U.S	13 Wa) 7 4	6 nic Origin? (Sp	ecify Ves or N			States ican Indian, Black,
leath w	Funeral	1 Never Married 2 M						exican, Puerto		- '	White, etc.	ican indian, black,
after call, on	by F	3 Widowed 4 X Div	orced If Yes, Give Year	- <u></u>	1 🔀	Yes 2 1	No s	pecify:Pue:	rto Ri	can	Specify: H	ispanic
hours 'natur Exam	ed	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grade College (1-		16a. Deceden	t's Usual Occup	pation	(Give kind of w NOT use retire	vork done	16b. Ki	ind of Business	Industry
36 hin 72 e. than '	ompleted	1 2	College (1-	40(3+)	R	ookkee	മവ	r			Priv	ate
5-00 led wit Hygien other	5	17. Father's Name (First, Middle	Last)			OORKEE		Mother's Name	(First, Middle,	Maiden S		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other the Medica	B		nce de I	eon	T 401 14 75			Carmer		ald		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is an areked other than "natural", or items 23a or 28a-f sho initing or other from mitter overset, the Medical Examiner must be notified as once	ြို	19a. Informant's Name/Relations Angel Ponce		Sr/son						mber, City	y or Town, State	e, Zip Code)
e, N I and Health Health		20a. Method of Disposition			lace of Disposi rematory or oth	ensbor ition (Name of o	cemete	ood La		20c. Lo	ocation - City or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ites		1 Burial 2 Cremation 4 Donation 5 Other Si	_	II Olale	-		c C	10/ remato	7/10	R.	iverda	le MD
Salti srmit. epartm nports		21 Signature of Funeral Service		1	22. N	ame and Addre	ess of I	Facility Ho	odges	& E	dwards	F.H.
		23a/ Part I. Enter the disease, or	complications that ca	Vs.	39	10 Sil	ve	r Hill	Rd.,	Su:	itland	MD. 20746 Approximate Interval
Physicia		failure. List only one cause	on each line.	ensive a		•	-				•	Between Onset and Death
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0, e be executed ysician and hurial - fransi	ledical	X UNPENDED	<u> </u>	7,per MI	F 0909	11/30/	10 '	——— ТТ				
Box 68760, a death certificate be the attending physic of for use as the burn	ě	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, or	utcome of pregna	ancy						Date of deliver	
Ox 6876 eath certificate attending phy for use as the b	sician/M	past 12 months?	I I LIVE DII	th nt at time of dea	- H	al death 3 ner (S <i>pecify</i>)	3 <u></u> E	Ectopic pregna	ncy	1 '	Month	Oay Year
BO)	Phys		9 Unknov									
P.O.	≥	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying caus	e giver	n in Part I.	_			the cause of death?
ds, P equires 1 een sign	ompleted								24a. Was		24b. Were au	utopsy findings available
Records, The law require ficate has been si	ם					_				rmed?	death?	completion of cause of
cal Recision: The certificate	C	25. Was case referred to medica			-	26.Pla	ce of E	Death (Check o		2 No	1 🗸 Y	es 2 No
Vita hysicis this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2 🗸 E	ER/Outpatient	3 DOA	Oth	er4 Nursing	g Home 5	Residen	ce 6 Othe	r.
n of ding P After funera	: 1	27. Manner of Death 1 X Natural 5 Pend	28a. Date o (Month, I	f Injury Day,Year)	28b. Time of Ir	_	-	Work?	28d. Describe	how injur	y occurred	
Division of Vital ral or Attenting Physician rs are death al Director. After this certified in by the fineral direction	Cati	2 Accident Inves	stigation 28e Place	of Injury - At hor	ne farm stree				28f Location (Street an	d Number or Ri	ural Route Number, City
Div pital or ours a c	Cert fication:		mined (Specify)	,,,,	,,	,,			or Town, S			,
		29a. Certifier 1 Certifying Pt	ysician: To the best									
To the Hox within 24 h To the Fut completely	Medical	2 🖳	miner: On the basis of and manner sta		d/or investigati				the time, date			
	29b. Signature and title of certifier 29c. License number 29d. Date signed (M. O.C.M.E. October 5, 2010)								mir, Day, (Gal)			
		30. Name and address of person	who completed cause	of death (Item 2	 23a)					1		
		Donna M. Vincenti, MI	O Assistant Me	edical Exami	iner 111	Penn Stree	et, Ba	altimore, MI	O 21201			
Regi	State		32. Reg	istrar's Signature	2.01							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

Reg. No. 32283

Physician/ Medical Examiner
Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	1 - State Of IV		ertificate of De		Reg. N	2010 32283			
an/	1. Decedent's Name (First, Middle, Last)			2	Date of Death	3. Time of Death			
an/ cal	Thomas James Patt	on		9	/23/2010	2:18 P M			
ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	c. County of Death					
	6801 Rum Point Lane 5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birthday)	Berlin If Under 1 Year	If Under 24 Hrs. 8		orcester			
	220–28–2485 Usual Residence of Decedent	Yrs. last birthday)		Hours Min. 2	Date of Birth (Month, Day, Year) /1/1933	Birthplace (State or Foreign Country) MD			
5	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits			
rect	MD Worcester	Berlin				1 ☐ Yes 2 🔼 No			
Funeral Director	10e. Street and Number	-	10f. Zip Code		10g. Citizen of What Country?				
Jer?	6801 Rum Point Lane		21811			USA			
	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.			
ted by	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.] No	1 ☐ Yes 2 X No			Specify: White			
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	(Give	edent's Usual Occupation we kind of work done during DO NOT use retired)	on ing most of working	16b.	Kind of Business Industry			
Be C	17. Father's Name (First, Middle, Last)		of Internat	tional Pha		reth Pharm. Co.			
2	Gordon S. Patton			Ellen Robi		,			
	19a. Informant's Name/Relationship (Type, Print)	19b. Mail				or Town, State, Zip Code)			
	Judy W. Patton (wife)	6801	Rum Point	Lane Berl	lin MD 21	811			
	20a. Method of Disposition	20b. Place of Disp		Date		Location - City or Town, State			
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		lopen Crem		010 Fra	nkford DE			
	21. Signature A-uneyal Service Licenses		22. Name and Address of William			uneral Home			
Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one act line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Out of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Out of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Out of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Out of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Out of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Out of the mode of dying, such as cardiac or respiratory arrest, Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
dica	d								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	23d. Date of delivery Month Day Year							
d by P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given	in Part I.		co use contribute to the cause of death?			
mplete					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
	25. Was case referred to medical		OR Disco	e of Death (Check on	1 Yes 2 1	No 1 Yes 2 No			
To Be	examiner?	ient 2 ER/Outpatie	_ Other		. /	6 ☐ Other (Specify)			
ie.	27. Manner of Death 28a. Date of inju	ury 28b. Time o			d. Describe how inju				
fica	2 Accident Investigation	y, reary mijury		s 2 🗆 No					
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, et	ury - At home, farm, st c. (Specify)	reet, factory, office	28f	f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certificate:	29a. Certifier (Check 2 ☐ Medical Examiner: On the basis of only one) 2 ☐ Certifying Nurse Practioner: To the	examination and/or inve	stigation, in my opinion, o	death occurred at the	e time, date and place	e, and due to the cause(s) and manner stated.			
-	29b. Signature and title of certifier		29c. License nu			ate signed (Month, Pay, Year)			
	30 Name and address of person who completed cause of c	death (Item 23a) (Type,	Print)	(1)4. 1	10 21	1/2/1/2/0			
te 🐇	31. Date filed (Month, Day, Year) 32. Relistr	ar's Signature	y Own	UTT 1	vui 21	0.10			
ar	SEP 2 8 2010 Serie	un B. 4	backer						

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DN 6+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ mer Month G 705pm 30 nna 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fahrney Keedi BOONSBORD MD Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** July 10, Year 1915 1 □ M 2 🖫 F Days Hours Min 214-09-5628 Maryland 95 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Washington Md. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10803 Crystal Falls Dr. 21742 U.S.A13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify White "natural", Specify. Completed 3 → Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ll Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Shoe Co. injury or other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evenione. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank B. Huntzberry Bertha N. Showe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma L. Coffman (Niece) 22154 Jugtown Rd. Hagerstown, Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Cemetery 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. Smithsburg, Mc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Jelle J.L. Davis Funeral Home MO1414 <u>Smithsburg,Md.</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Demenic Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, it amy leading to immediate cause. Enter Underlying Examine FIDEILLATION Cause (Disease or iinjury ttnai been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed 2 🗌 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after deu val Director: Affr vv the fi Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier R128088 Kate yn Smith 10-1-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SMITH CRNP opal Ct. Hagerstown, MD 21740 1126 32. Registrar Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roy Parker sepember 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 924 Booker Drive Capital Heights | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) | 04/30/1936 Social Security Number 9. Birthplace (State or Foreign Country) DC 7. Age (In vrs. last birthday) **Funeral** 1 🔀M 2 🗆 F Director 577-50-9291 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director MD PG Capital Heights 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be by Funeral 924 Booker Drive 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? 1

✓ Yes 2 □ No Black, White, etc 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give 960 – 66 Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th Truck Driver Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Lof Health and tem 27 is man. ပ္ Jeannette Robinson unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty S. Parker/ Wife 924 Booker Drive; Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/6/2010 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signal e Freeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services MD 20748 4594 Beech Road; Temple Hills, 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Dementia Physician/ disea e or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to (or se a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) 1 Yes 2 L 9 Unknown a | i Inknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 🔽 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manper of Death 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 🚅 🇲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Ms Rajapathelm D DOUS7465

State Registrar AV-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith

N.S. Rajaparkse, M.D.

2010

31. Date filed (Month, Day, Year)

SEP 3 0

9/28/10

5203 Baltimore, MD. 21209

Please Type or Print in Black Indelible 10k1 Ensure Alk Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Renshaw 2010 Emma F. 1915 Sept. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital Elkton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👺 F Months Days Hours Sept 23 1957 218-70-3100 Leesburg, VA Director 53 Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cecil. 1 🗌 Yes 2 🙀 No MD **Earlville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21919 15 Glenwood St. USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Statue 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important. If item 27 is marked o any injury or other traumatic eve once. ည Doris Ellen Funk Charles Cahall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earlville, MD 21919 Charles Funk (son) 15 Glenwood St. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept.29,2010 Wilmington, DE McCrery Crematory 21. Signature of Funeral Service Licensee NOO 22. Name and Address of Facility アちら McCrery Funeral Homes, Inc. 3924 Concord Pike Wilmington, DE 19803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Kespintle †
Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical # 74 #8 (LeC. | Co. | Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin the detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical To Be filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 2 27. Manner of Death Other: 2 🗌 No 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge death of 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUI CHILL HSU, MD 223 West 223 West man St, Elicton, Md 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 3.05 pm **Physician** Virginia 06 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hacerstown Washing Hagelstown NMS If Under Year | If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Hours Months 1 □ M 2 🗓 F ΜĎ 74 02/18/1936 214-34-0208 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County show at 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified Director MD Big Pool Washington 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number with IISA 21711 13427 Pecktonville Road items 23a Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Examiner Black, White, etc. within 72 hours after 1 ☐ Yes 2 🕅
If Yes, Give
Year or Dates: 2 X No 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: White ģ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical I be filed within ntal Hygiene. ed other than " Elementary/Secondary (0-12) College (1-4or 5+) Electronics Manufacture 12 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental is marked Amanda L. Mills Kenneth E. Reed ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 is
any Injury or other trau 810 Coon Hollow Road Warfordsburg, PA 17267 Gerald D. Reed/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/11/2010 Big Pool, MD 4 Donation 5 Other (Specify) Parkhead Cemetery 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Actor Physician oronary disease or condition resulting in death) /Medical Due to (or as a consequent e of): **Examiner** ac Kinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has 1□ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 □ Innatient Certification: To this spital or Attending Physhours after death.
Ineral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Hophanie Comer-Conordiality

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:31 AM <u>Luis Alfredo Herrera Ramirez</u> eptember 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Doctors Community Hospital Prince Georges

9. Birthplace (State or Foreign Lanham . Age (In yrs. last birthday) If Under 24 Hrs. 8, Date of Birth **Funeral** 1 XM 2 - F Months Hours Min. (Month, Day, Year) **Director** 1984 Guatemala March Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince Georges 1 Yes 2 No Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6206 58th Avenue 20737 Guatemala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 XMarried þ Yes 2 No 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Guatemalan White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter and Mental Hygie is marked other Hannahan, Co Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ pe Juan Antonio Herrera Garcia Gilma Lisbeth Ramirez l and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dinora Martinez (Wife) 6206 58th Ave. Riverdale, MD 20737 permit. Page 1 and 2:
Department of Health
Important: If item 27
any injury or other tr
once. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Penten, Guatemala 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cementerio Municipal 10/4/2010 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signatu of Funeral Service License 9013 Annapolis Rd. Lanham, MD 20706 Deft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 51 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Lisease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ACIDEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed ANCYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has LMMUNO DEFICIENCY After this certificate 2 🗌 No 1 Ves 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending in 24 hours are: Let he Funeral Director: Af ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29d, Date signed (Month, Day, Year) 091-30-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAN Lanham MD 8118 20706 (500d State OCT 0 1 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 25 Physician/ Rayburn C. Robinson, Jr. 2310 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita Rockville Montgomery Shady Grove 2010 Adventist If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours (Month, Day, Yea 577-44-6509 Director 76 April 1934Washington, Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d Inside City Limits Director 1 X Yes 2 No MD Poolesville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20837 USA 17316 Dowden Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?
1

Yes 2 □ No Black White etc. Completed by 1 Never Married 2 X Married hours after If Yes, Give 1 Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates. 1952 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 and Mental Hygiene. Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) Fishery Biology Dept of Interior be filed v Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Ray 2 Scott Laura Rayburn Robinson and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 17316 Dowden Way Poolesville, MD. Joni Robinson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 9/30/2010 Brentwood, MD 21. Signature of Funeral S 22. Name and Address of Facility 3401 Bladensburg Rd ances Brentwood, MD 20722 Fort Lincoln Funeral Home 23a. Part 1. Enter the di , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Fina Physician, multiple strokes disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner peripheral vascular disease Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). multi-infarce the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Coronary disease Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the and to be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b oneumonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes 24a Was an this certificate has performed Ischemic 895 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 WNo မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? _1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. e Funeral Director: After Watural | iniury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 D0055054 september 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Ave Suite 109 Gaithersburg MD 208 Kasid 604 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 3 0 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32290 State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 2. Date of Death Physician/ SEPTEMBER 25 2010 12NOON M ROBINSON LONNIE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE 231 N. PATTERSON AVENUE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Year) 946 Months Days Hours Min. (Month, Day, Y OCT • 16 1 X M 2 D Yrs. TEXAS Director 453-72-5029 63 Usual Residence of Decedent show 10b. County be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE MDBALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 231 N. PATTERSON AVENUE 21231 n "natural", or item ledical Examiner m 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give 1 ☐ Yes 2 X No Specify: BLACK 3 Widowed 4 😾 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CAR SALES MANAGER PRIVATE is marked other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott aff) Niury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ LONNIE HIGHTOWER CLIFTON ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14715 ARGOS PLACE UPPER MARLBORO, MARYLAND 20774 DORI WILLIAMS/FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY 9/30/2010 CHELTENHAM, MARYLAND J. B.JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner **HYPERTENSION** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 2X No Yes 2 X No 1 Tes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 2 Within 2 To the 1 29b. Signature and title of certifier 4403 who completed cause of death (Item 23a) (Type, Print) ANDREW DOBIN M.D. 4175 N HANSON COURT # 203A BOWIE, MARYLAND 20716

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

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[] 30 Mame and address of person who completed cause of death (Item 23a) /Time Print)	. ₽ ∅	_	250. Signature and use Of Certifier		D0053815	29d.	2/2/2/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 32292 Certificate of Death 1. Decedent's Name (First, Middle, Last)/ 2. Date of Death 3. Time of Death NIEL 075 Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Hospice House Harwood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. Yrs Director /3/194 66 214-42-3374 Usual Residence of Deceden or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes XX No MD Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 932 Ships Bell Ct. 21401 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2xxMarried ō þ 1 ★ Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Manager Property Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold Austin Stevens Madalyn Overath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Stevens Spouse 932 Ships Bell Ct. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 9/28/2010 |Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 70 12 Ridgely Ave, Annapolis, MD 2140 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between t rd eath Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law lequires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 1 L Yes 2 L 9 L Unknown een signed by the nould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? 2- No 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: BORIN HOSPI 2 No 욘 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertif Date signed (Month, Day, Year) ember

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Registrar

30 Name and address of person

31. Date filed (Month, Day, Year SEP

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who completed cause of death (Item 23a) (Type, Prin

32. Registrar's Signature

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Baltimore,	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene Important: if item 27 is marked other then 'any injury or other traumatic event, the Manning.		21. Signature of Funeral Service Lic	ensee		22	2. Name and	Address	of Facility		Sal	isb	urv. Ma	rvla	nd
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Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Contributed Contributed				For State		State of Ma	aryland /				Mental Hy	/gien/į	9010	32294
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Physician Medical Examiner Physician					ease, or comp ire. List only o	lications that caused one cause on each lin	the death. [ne.	o not enter the mo	ode of dyir	ng, such as cardia	c or respiratory	arrest,		Interval Between
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Sequentially all conditions contributing to death but not resulting in the underlying cause given in Part I. Comparison of the contribution of				resulting in death)		Due to (or as	a consequen	ce of):	Wa A	mtic				112005
Due to (or as a consequence of): Comparison of the control of t			ē	Sequentially list condition if any, leading to immedia	ns, ate	b. Due to or as	a consequen		17/6	7770				years
Second S		uted d ansit	mj.	cause. Enter Underlying	-	C								
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236. If yes, outcome of pregnancy 1 1 1 2 2 2 2 2 2 2	876	ate be hysici the bu	lical		•	d								
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30. Name and address of person who completed caused death (Item 23ay (Type, Print) for the Salisbury, MD 21802 State 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature	000	Phys r this ral du	 			1 L Inpatie			JOA	4 Mursing I				ocify)
30. Name and address of person who completed caused death (Item 23ay (Type, Print) for the Salisbury, MD 21802 State 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature	TAP	nding th. : Afte	tlor	1 Natural 5		(Month, Day	y Year)	Injury					•	
30. Name and address of person who completed caused death (Item 23ay (Type, Print) for the Salisbury, MD 21802 State 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature	VIS. F.	Atter	HICE	3 Suicide 6	Could not be determined	28e. Place of Inju	ury - At home	, farm, street, facto	ory, office		28f. Location	(Street a	and Number or R	ural Route Number,
30. Name and address of person who completed caused death (Item 23ay (Type, Print) for the Salisbury, MD 21802 State 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature	ق	tal or rs afte el Dir	Cert		_	building, etc	(Specify)				53 Um	72	Deers	Head Hospital
30. Name and address of person who completed caused death (Item 23ay (Type, Print) for the Salisbury, MD 21802 State 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature		n 24 hou he Fune pletely fil	edical	(Check only 2 1	Certifying Phy Medical Exam	iner: On the basis of	examination	dge, death occurre and/or investigation	ed at the ti	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(e, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Vithi To t	×	29b. Signature and title o	certifier	F. Kelly	,	2	9c. Licens	0069	754	29d. D	ate signed (Mon	th, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		251		- //	person who	empleted cause of	eath (Item 23	ay Type, Printy/	7iz	1 Go Fen	- Ja/12	obu.	M. MD	21802
					y. Year) 23 20		ar's Signature	bare	1			4	#	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Virginia Smith September Sherman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 202 E. Church Street Carrol1 Mt. Airy **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🏝 F Months August 9, Hours Year) Mary land Director 219-14-0829 87 1923 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Carrol1 Maryland Mt. Airy 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 202 E. Church Street United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🖾 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates d Mental Hygiene. marked other than "natural", 3 Midowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 12 Public Schools Cafeteria Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Mortimer Sherman Amanda Elizabeth Rimby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Smith / Son 6107 Ravenwood Road Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State September Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 30, 2010 Mt. Airy, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the _see'se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or ____ ch line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 1 Yes 2 9 Unknown signed by the a Id be detached f g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate I 1 Yes 2 No Yes 2 the Hospital or Attending Physician: I thin 24 hours after death. the Funeral Director: After this certifica mpleted filled in by the funeral director, p Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number

3. Time of Death

10d. Inside City Limits

Approximate

Day

Year

1 X Yes 2 No

11:24 A^M

State Registrar

30. Name and address

DHMH 17 Rev 7/2009

of person who completed cause of death (Item 23a) (Type, Print)

	•	For State Registrar	State of iv	iai yiai iu		tificate of L				Reg. N	2010	3229
Physicia		Decedent's Name (First, Middle JAMES	e, Last)		SCOTT				Date of De Month EPTEM	ath BER	^{ay} 26 2010	3. Time of Death 6:15 P
Medic Examin		4a. Facility Name (if not institution LARKIN CHASE	,	ME		4b. City, Town, o	r Location			4	c. County of Deat	th
Funeral Director		5. Social Security Number 244-38-3458	4 DYM O DE	ge (In yrs. last 79	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min. S	Date of Bir (Month, Da EPT •	th y Year) 28	9. Bir 1930 NOR	thplace (State or Foreign ountry) TH CAROLINA
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified at once.	irector	Usual Residence of Decedent 10a. State 10b. County MD PRINC	E GEORGE'S		Town or Loc							10d. Inside City Limits X☐ Yes 2 ☐ N
th with the ms 23a or must be n	Funeral Director	10e. Street and Number 3507 JEFF ROAD		-	Lag v	10f. Zip Code 2077				10g. C		
rs after dea ıral", or itel I Examiner	by	11. Marital Status1 ☐ Never Married 2 [X] Married3 ☐ Widowed 4 ☐ Divorced	If Von Cive			Vas Decedent of H Yes, specify Cuba			/ Yes or No- an, etc.)		14. Race - Ame Black, White Specify:	
ithin 72 hou iene. r than "natu the Medica	Completed		nt's Education est grade completed) College (1-4 or		(Give k life. DC	ent's Usual Occup ind of work done NOT use retired)	ation during mo	st of working			Kind of Business	Industry
d be filed w Mental Hygi arked other atic event, 1	To Be	17. Father's Name (First, Middle, LERNEST SCOTT	ast)		LING	INEER		her's Name <i>(F</i>		Maider	Surname)	
nd 2 shoul ealth and I m 27 is m ner traums		19a. Informant's Name/RelationsI			3507	g Address (Street JEFF RO						,
t. Page 1 a rment of H rtant: If ite rjury or oth		20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	cen	netery, crem ATION	sition (Name of patory or other place AL CEMET)	ERY		2010	LA	Location - City or UREL, MAR	YLAND
Departition Departition Departition Departition Departies and in Departies and in Departition Departit		21. Signature of Furieral Service L	licensee		74	. Name and Addre 474 LAND(ss of Facil	ROAD H	JENK YATTS	INS VILI	FUNERAL LE,MARYL	HOME, INC. AND 20785
Physician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each ling a. META	ne.	PROST	r the mode of dyin		s cardiac or re	espiratory an	rest,		Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C	a consequer						_		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1	2 Fetal c	death 3	Ectopic pregnand Other (specify)	;y				23d. Date of de Month	livery Day Year
uires that th n signed by uld be detad	by	Part II. Other significant condition	ons contributing to death	but not result	ing in the ur	nderlying cause gl	en in Par	t I.				the cause of death?
The law req cate has bee page 2 shou	Completed								24a. Was autor perfo 1 Yes	rmed?	prior to death?	topsy findings available completion of cause of
iysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【【 No	Hospital: 1 ☐ Inpat	ient 2 🗆 EF	R/Outpatien	Oth		ath (Check on		lence	6 ☐ Other (Spec	ify)
ttending PP death. :tor: After th / the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation not be	ay, Year)	8b. Time of injury	28c. Injur work M 1 -	/ at	⊇8d □ No	i. Describe h	ow inju	ry occurred	
pital or A burs after eral Direc filled in by		4 ☐ Homicide determ 29a. Certifier 1 ☑ Certifying		c. (Specify)			doto and		City or Tow	n, State	e)	ral Route Number,
o the Hos rithin 24 h o the Fun ompleted	Medical	(Check 2 Medical E	examiner: On the basis of Nurse Practioner: To the	examination a	nd/or investi	gation, in my opinio	on, death o e time, dat	occurred at the	time, date a	nd place e cause	e, and due to the	cause(s) and manner stat stated.
		30. Name and address of person	And complete the sure of	teath (Item 2	3a) /Tupe Pi	D43					TEMBER 2	
Stat	ρ.	IKECHI OKWARA 31. Date filed (Month, Day, Year)	M.D. 12200	ANNAP(OLIS I	ROAD SUTT	E 31	6 GLEN	N DALI	E, MA	RYLAND_	20769
Registra		SEP 3 0 2010	anne D.	par	es!				_			

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato of Marylan		tificate of i		viorital 113	Reg. No	711111	32297
	Physici /Medic		1. Decedent's Name (First, Middle, Las	SMIT	H			2. Date of Do Month	eath Da	y 2010	3. Time of Death 4.05 P M
	Examir	er	4a. Facility Name (If not institution, given DORCHESTER GE	,	TAL	4b. City, Town, or CAMBA				ORCHE	STER
	Funeral Director		219 12 0040	6ex 7. Age (In yrs. 1 ☐ M 2 ☐ F 9 2		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Aug. 1	ay, Year)	Co	thplace <i>(State or Foreign</i> nuntry) ryland
	e Maryland Ba-f show	Director	Usual Residence of Decedent		, Town or Loc		ston				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 501 Dutchman's	s Lane		10f. Zip Code	21601			tizen of What Co Lted St	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mulicel Exerting at must be rectified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 ☒️ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Vas Decedent of H fYes, specify Cuba □Yes 2∏xNo		pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	d within 72 hagiene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+) 5 +	(Give) life. D	lent's Usual Occup kind of work done o DO NOT use retired DINEY	during most of worl	king	Ī	ind of Business/	
and	should be filed and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Charles H. Sm				18. Mother's Nam	ette B		ŕ	
Mary	nd 2 shoul Ilth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (M. Hugh Smith, Ju		1	g Address (Street a					Zip Code)
imore,	Pages 1 and nent of Health ant: If item 27 ury or other tu		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	inemoval nom state	lace of Dispos emetery, crem	sition (Name of natory or other place). Cemeter	e)	Date	20c. Lo	ocation - City or	Town, State
Balt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licen	CF5P	22.	Name and Addres	in St., I	amptom l Federals	Fune: Sburg	cal Home	e. P.A.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or company shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ASPIRAT Due to (or as a consequence of the consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	rence of):	PNE	LURE JMONI	A			Approximate Interval Between Onset and Death
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O. Box 6	eath certi attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3 🗆	Ectopic pregnancy	/			23d. Date of deli Month	ivery Day Year
ds, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the un	derlying cause give	en in Part I.		tobacco i		the cause of death?
r	The ate h	Completed		-				24a. Was auto perfo	psy ormed?	prior to death?	itopsy findings available completion of cause of
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 LI Nursing H		idence	6 ☐Other (Spec	cify)
DIVISION	ttal or Att ins after de ral Directu led in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ne, farm, stre	et, factory, office		28f. Location (City or To			ıral Route Number,
	the Hosp nin 24 hou the Funei npletely fil	Medical	(Check only 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinate and manner stated.	ion and/or inv	restigation, in my o	pinion, death occu	rred at the time	date and	d place, and due	to the cause(s)
	So V Will	2	29b. Signature and title of certifier	completed cause of death (Item Arifuddow) 2. Registrar's Sign		DOC	6746	5	29d. Da	te signed (<i>Montf</i>	h, Day, Year)
			30. Name and address of person who of	completed cause of death (Item	23a) (Type, F	Print) 3 5. Wash	hington S	it, Ea	stor	J, MD	21601
	Sta Registra		31. Date filed (Month, Day, Year) 0CT 0 1 2010	2. Registrar's Sign	ure	d'	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elmore Wilson Tyler State of Maryland / Department of Health and Mental Hygiene 2010 32298 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Y September 30, 2010 Tyler **Medical Examiner** Elmore Wilson 1542 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director Mar. 25, 1936 227-46-2413 1X M 2 F 74 Country) Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits iny VΑ 1 Yes 2 XXNo King George King George permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tramnatic event, the Medical Is. aminer must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4506 Danube Drive 22485 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 No Black 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify. 1955 þ 16b. Kind of Business/Industry U.S. Dept. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) h and Mental Hygiene. 27 is marked other than "n matic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) Treasury Security MD 21215-0036 2yrs 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) William H. Jordan Maggie Tyler 19b. Mailing Address (Street and Number or Rural Route Number Eitg of Town, Flate-Zip Appe) 19a. Informant's Name/Relationship (Type, Print) Christine D.Johnson, sister 3400 Woodbridge Ct., 20b. Place of Disposition (Name of cemetery, ^{Date} 2010 20a, Method of Disposition 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State Meadow BrookeMem. King George, VA Oct.6, 4 Donation 5 Other Specify Garden 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 12055 James Madison Pkwy. King George, VA Part Enter the disease, or complication failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical g physician a the burial -UNPENDED AMENDED Hospital or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? . death? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 Other DOA After this 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Sep 30, 2010 Subject driver of vehicle involved in motor 1 Natural after death.

Director: / 5 Pending 1 Yes 2 ✓ No vehicle accident 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Direc Suicide Could not be or Town, State) N/B Route 301 at Heathemore Boulevard, Upper Marlbor determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME O.C.M.E. October 1, 2010 completed deuse of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

end Item 8 State of Maryland / Popertment of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 0

			State Registrar		Cei	tificate of Death		giene Reg. No 2010	32299
	Physicia Medio		1. Decedent's Name (First, Middle Arveda E.				2. Date of De Month Sept.	ath 24,2010 Year	3. Time of Death 5:35pm M
	Examin		4a. Facility Name (if not institution Crofton Conva		er	4b. City, Town, or Location Crofton	of Death	4c. County of De	ath
	Funeral Director		5. Social Security Number 045–20–6079		e (In yrs, last birthday) 87 Yrs.		wr 24 Hrs. 8. Date of Bir Min. 11707/	th 9. B	irthplace (State or Foreign ountry) nnsylvania
	laryland 3a-f show iffied at	Director	Usual Residence of Decedent 10a. State 10b. County MD Prince	e George's	10c. City, Town or Lo				10d. Inside City Limits 1XXYes 2 □ No
	s 23a or 28 s ust be not	Funeral Dir	10e. Street and Number 6501 Queens C		[ONI VEIDIE	10f. Zip Code 20782		10g. Citizen of What C	Country?
920	s after death 'al", or item Examiner m	by	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorced	If You Give	No I	Vas Decedent of Hispanic Or f Yes, specify Cuban, Mexica □ Yes 2 🏿 No Specify	an, Puerto Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decede (Specify only high Elementary/Seconday (0-12)	ent's Education est grade completed) College (1-4 or 5	(Give life. D	lent's Usual Occupation kind of work done during mos O NOT use retired) Ionemaker	st of working	16b. Kind of Busines Own Home	s Industry
land 2	be filed within lental Hygiene. rked other tha ic event, the I	To Be C	17. Father's Name (First, Middle, William E. Rhi	•		18. Moth	her's Name (First, Middle,	Maiden Surname)	
Maryland	2 should be fil th and Mental 27 is marked traumatic ev		19a. Informant's Name/Relations David M. Redze	hip (Type, Print)		ng Address (Street and Numb	per or Rural Route Numbe	r, City or Town, State, 2	
Baltimore,	~ ~ = -		20a. Method of Disposition 1 🛣 Burial 2 🗆 Cremation 4 🗆 Donation 5 🗀 Other (3	3 Removal from State	20b. Place of Dispo cemetery, cren	Queens Chape sition (Name of natory or other place) V Cemetery	Date 9/30/2010	20c. Location - City of	or Town, State
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service	ricensee		Name and Address of Facil	ity Beall Fune	eral Home	
	Pnysician/ Medical Examiner		23a. Cart 1. Enter the clease, of shock, or heart failure. List Immediate Cause Final disease or condition resulting in death)	only one cause on each line	the death. Do not ente	or the mode of dying, such as	s cardiac or respiratory an	•	Approximate Interval Between Onset and Death Mon This
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с. —	a consequence of):	1			6 years
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	physi the t	edic		d					
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f Vital Records, P.O. Box	or Attending Physician: The law ifter death. Director: Affer this certificate has in by the funeral director, page 2	Certificate: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1	Hospital: Hospital: 1 Inpatie	2 Fetal death 3 L t time of death 5 L ut not resulting in the u ent 2 ER/Outpatien ry (, Year) 28b. Time of injury ury - At home, farm, stre	26. Place of Deater 3 DOA Other: 4 N 28c. Injury at work? M 1 Yes 2 Let, factory, office	24a. Was autor performent of the control of the con	Month bacco use contribute to the second se	Day Year To the cause of death? Probably 4 Unknown utopsy findings available to completion of cause of as 2 No cify) ural Route Number,
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			partment of Health and I	Mental Hygie	ene	22200
		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	g. Ng. U	32300
Physic Me	cian/ dical	David Ivan Thomas		2. Date of Death	24 2010	3. Time of Death 0204 M
Exan	niner		4b. City, Town, or Location of Death	1	4c. County of Death	
Funer	ما	Washington County Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hagerstown () If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washin	
Direct		216-54-8548 1 M 2 □ F 60 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1950 Mai	place (State or Foreign try) cyland
nd how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			0d. Inside City Limits
faryla 3a-f s tified	ect	Maryland Washington Hagersto	N.T.			1 ☐ Yes 2X No
the M	Funeral Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?
n with ns 23s nust b	nera	1536 Crest View Avenue	21740		United St	ates
deatl r item			Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	an Indian,
336 s after al", o Exam	d b	1 Never Married 2 Married 1 May Yes 2 No If Yes, Give	1 ☐ Yes 2 🖾 No Specify:		Specify:	
hours natur	lete	3 Widowed 4 Divorced Year or Dates. 1968-72 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	White 6b. Kind of Business Inc	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	e kind of work done during most of work DO NOT use retired)	king		,
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ary hould and M s mar			iling Address (Street and Number or Rur	Virginia S		Code)
		1	Crest View Avenue			*
Ore Total		20a. Method of Disposition 20b. Place of Dis	position (Name of	Date 20	Oc. Location - City or To	
Baltimore, bermit. Page 1 and Department of Hea Important: If item		4 Donation 5 Other (Specify) Harmony	Brethren Cemetery 22 Name and Address of Espility	7/2010 N	Myersville,	Maryland
Baltimo permit. Page Department of Important: If any injury or	ouce	bdil Allende Is	22. Name and Address of Facility tauffer Funeral Ho 621 Opossumtown Pi	omes P. A.	Prick Mary	land 21702
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	, nary	Approximate Interval Between
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he death of the atter	Completed by Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		Month	Day Year
that the ned by e deta	oy P	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobac	cco use contribute to th	e cause of death?
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The cate it page				performed		2 🗆 No
VILCII ysician: s certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check	k only one)		
or Physical distriction	e: To	27. Manner of Death 28a. Date of injury 28b. Time	ent 3 🗆 DOA 📗 4 🗀 Nursing Ho	ome 5 Residence 28d. Describe how in	e 6 Other (Specify)	
ath. rr: Afte	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 ☐ Yes 2 ☐ No		.,,	
DIVISION OF VITAL RECORDS, F.O. BOX 05/17 to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural (tate)	Route Number,
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he Hoo in 24 h he Fur ipleted	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at	the time date and of	lace and due to the cau	ea(e) and manner stated
To t with To th		29b. Signature and title of certifier	29c. License number		. Date signed (Month, D	ay, Year)
		Michael Milan MD	041667		4.52.	10
15tIVA		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Nedical Co- faces	mar 1	k wahun	mo
St	ate	31. Date filed (Month, Day, Year) 28 20 32. Regist r's Signature	1/2 Mal	VI-2 IV		
Regist	ıar	OLI NO LOS PARAMOS P.	Page WV VIII			

		•	for State Registrar	01410 01 11	iai y iai ia	Cei	tificate of L		oman	Reg. N	No.	
	Physicia	n/	1. Decedent's Name (First, Middle	e, Last)					2. Date of De Month		Day Year	3. Time of Death
	Physicia Medio			White							2010	9:35 P ^M
	Examin	er	4a. Facility Name (if not institution		ohah	C+m		r Location of Deatl	h	1	4c. County of Death Prince G	
*spring"	Funeral		Patuxent River 5. Social Security Number		ge (In yrs. las		If Under 1 Year	If Under 24 Hrs		th_	g. Birt	hplace (State or Foreign
	Director		578-68-8905 Usual Residence of Decedent	1 □ M 2 🛂 F	59	Yrs.	Months Days	Hours Min.	Sept.	22, Year	1950 Co.	DC DC
	and show	ō	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl 28a-f otified	Director	Maryland Princ	ce George's				Laurel				1 X Yes 2 ☐ No
	a or 2	O E	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	untry?
	h with ns 23 nust	Funeral	14200 Laurel H					20707			nited Sta	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status 1 ☑ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🌣 No		pecify Yes or No- o Rican, etc.)			
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ary	hould and M s mai		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbi	er, City	or Town, State, Zip	Code)
Σ	nd 2 salth an 27 i		Kim White-Harv	ell / Daught	er	440(Birchtr	ee Lane	Temple	Hil	lls, Md.	20748
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth	D H	20a. Method of Disposition 1 ॲBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (sition (Name of natory or other plac 201n	^{ce)} Sep 2010	Date t. 30,	20c.	Location - City or Suitlan	Town, State d, Maryland
Balt	permit. Departr Import. any inji		21. Signature of Juneral Service	censee	V	V /	. Name and Addre				neral Hom	-
		\equiv	23a. Part Ex er the disease, o					_				Approximate
نسد	Physician/		Immediate Cause (Final disease or condition	An	ovic .	E	nceph	alona	the			Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a conseque		1-1-1	1	1			
	LAdillilei	į.	Sequentially list conditions, if any, leading to immediate	6 -								
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a conseque	nce ot):						
	xecuto n and al-trar	Еха	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):					-	
0	ate be executed physician and the burial-transit	Medical		d								
8760	ificate ng phy as the	Med	IF FEMALE:	1								
Box 6	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Petal of de	death 3	Ectopic pregnand Other (specify)	су			23d, Date of deli Month	very Day Year
, P.O.	es that the signed by be deta	by	Part II. Other significant condition					ven in Part I.				the cause of death?
g	require been si should	etec	A-000	elisional		7	2 1		24a, Was			opsy findings available
Division of Vital Records,	The law cate has page 2 s	Completed	Treme	g Chow	ruc	80	eases		auto	psy ormed?	prior to c	ompletion of cause of 2 No
ta	iician; The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	ace of Death (Che				
<u>></u>	Physic rthis caral dir	2	1 Yes 2 No 27, Manner of Death	28a. Date of inju	ury 2	R/Outpatier 8b. Time of	it 3 🗆 DOA	4 Nursing I	dome 5 Resi		6 Other (Speci	fy)
n	nding I tth. : After e funer	cate	1 Natural 5 ☐ Pendi	(Month Di	ay, Year)	injury	work		200. 00001100		ary occurred	
ivisio	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific sted filled in by the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e. Place of In	jury - At hom tc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To		and Number or Run te)	al Route Number,
Ω	To the Hospital or within 24 hours after To the Funeral Dir completed filled in		29a. Certifier 1 ertifying	Physician: To the best o	f my knowled	dge, death o	occured at the time	, date and place, a	and due to the ca	ause(s)	and manner as sta	ted.
	he Ho in 24 l he Fu ipleter	Medical		Examiner: On the basis of Nurse Practioner: To the								
	North Vorm Com	-	29b. Signature and title of certifle				29c. License	e number	((29d. C	Date signed (Month	, Day, Year)
			- Kuta Nha	wan, MD			ال ا	06253	4		7/28/	2010
r	2		▶ Rita Pho 30. Name and address of person RITA DHAN	who completed cause of a	1055	(Type, F	violet ?	r, Sinte	103,E	llic	ot City	MD-21042
	Stat Registra	te	31. Date filed (Month, Day, Year) 0CT 0 1 2010	Server 32. Registr	's Signatur	ales!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		tificate of L		, ,	eg. No.2010	32302
	Physicia Medic		Decedent's Name (First, Middle, Las IRENE	t)	WA	LKER		2. Date of Dear Month SEPTE		3. Time of Death 10 9:40P M
	Examin		4a. Facility Name (if not institution, give 5515 CHESTERFIE			4b. City, Town, or TEMPLE	Location of Death		Ac County of Dea	
Ī	Funeral Director		5. Social Security Number 6. Se 236–56–3670	ex 7. Age (In yrs 7. 1	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, JUNE I	9. Bit 5 1939 WES	thplace (State or Foreign
	rland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a- notifie	Jirec	MD PRINCE G	EORGE'S	TEMPLE					1 X Yes 2 □ No
	with the s 23a or rust be r	Funeral Director	10e. Street and Number 5515 CHESTERFIEL	D DRIVE		10f. Zip Code 20748			10g. Citizen of What Co USA	ountry?
9036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	"	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🛣 No	in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	thin 72 hou ene. than "natu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12) 1 2 TH	ducation ide completed) College (1-4 or 5+)	(Give I	dent's Usual Occup kind of work done o O NOT use retired)		king	16b. Kind of Business	Industry
ر ام	iled wi Il Hygik I other vent, t	Be	17. Father's Name (First, Middle, Last)		CLE	·uk	18. Mother's Nam	ne (First, Middle, N		
ylar	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	ပ္	MOFFETT WASHINGT	ON			NANCY	MARSHA	LL	
Mar	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (7)						City or Town, State, Zi	
ď.	pe 1 and 2 t of Health If item 27 or other tr		TERRA BRYANT/DAU 20a. Method of Disposition		. Place of Dispo	sition (Name of			E HILLS, MA 20c. Location - City or	RYLAND 20748 Town, State
m 0	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Specif			natory or other place E CREMATO		/2010	RIVERDALE,	MARYLAND
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Conature of Funeral Sevice Licens	ее		Name and Addres	J		INS FUNERA ER MARYLAN	
Ī			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the dene cause on each line.						Approximate Interval Between
	Physician/ Medical	9	Immediate Cause (Final disease or condition resulting in death)	a. LUNG CA						Onset and Death
	Examiner	L	Sequentially list conditions,	bue to (or as a conse	equence on.					
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or limitry	Due to (or as a conse	equence of):					
	cate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
760	- 6	ledical		d						
P.O. Box 68	or Attending Physician: The law requires that the death certifics after death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as:	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnanc Other (specify)	Ży		23d. Date of de Month	llivery Day Year
O. O.	that th ned by e detac	by Ph	Part II. Other significant conditions co	ontributing to death but not i	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
ds,	v requires that s been signed k should be det	ted I						1 💢 Y	es 2 No 3 F	robably 4 Unknown
Recol	s ician: The law re certificate has be irector, page 2 sh	Completed						24a. Was a autops perfori 1 \(\sum \) Yes	sv prior to	ntopsy findings available completion of cause of s
ta	is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Othe	ace of Death (Chec er:			
Division of Vital Records,	nding Phys tth. ; After this e funeral di	icate: To	1 Yes 2X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	4 L. Nursing He / at	21	ence 6 Other (Spec w injury occurred	cify)
Divisio	tal or Attencrs after death	Il Certificate:	3 Suicide 6 Could not by 4 Homicide determined			eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	the Hospital thin 24 hours the Funeral I mpleted filled	Medical	(Check 2 Medical Exami	sician: To the best of my kno ner: On the basis of examinat the Practioner: To the best of	tion and/or invest	igation, in my opinio	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.
	To the within 2 To the Comple		29b. Signature and title of certifier	nul		29c. License	e number 8948	2	9d. Date signed (Mont SEPTEMBER	h, Day, Year) 28, 2010
0	- 5		30. Name and address of person who common TABBARA M.	ompleted cause of death (Ite	em 23a) (Type, P	Print)		OO WASHT	NGTON, DC 2	
1	Stat	e		32. Registraris Sign			,0111 1 1	O WINDIII		
	Registra	ir	OCT 0 1 2010 A	Kround B. 1	g aura					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	Takoma thday) If Under 1 Year Months Days	Location of Death Park If Under 24 Hrs.	2. Date of De Month 0.9	Day 24	3. Time of Death 2010 11:53 a M
Harvey Eugene Wooldridge 4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (in yrs. last birt. 233-40-7347 84 Usual Residence of Decedent	Takoma thday) If Under 1 Year Months Days	Park If Under 24 Hrs.		24	Year
4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital 5. Social Security Number 233-40-7347 Usual Residence of Decedent 4a. Facility Name (if not institution, give street and number) 7. Age (in yrs. last birt.) 84	Takoma thday) If Under 1 Year Months Days	Park If Under 24 Hrs.	V2		
5. Social Security Number 233-40-7347 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birt. 84	thday) If Under 1 Year Months Days	If Under 24 Hrs.		4c. County	of Death
233-40-7347	Yrs. Months Days				gomery
Usual Residence of Decedent		Hours Min.	8. Date of Birl (Month, Da 07/07/	v. Year)	9. Birthplace (State or Foreign Country) West Virginia
MD Prince Georges Hyatt 10c. City, Town 10c. Street and Number	and and analysis	<u> </u>	1.07.707.7	1920	west viiginia
MD Prince Georges Hyatt	n or Location				10d. Inside City Limits
Too. Greet and Namber	tsville 10f. Zip Code			10g. Citizen of V	1 ★ Yes 2 No
5804 43rd Avenue	207	Ω1			SA
11. Marital Status 12. Was Decedent Ever in U.S. Argued Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe	ecify Yes or No-	14. Rac	e - American Indian,
1 Never Married 2 Married 1 X Yes 2 No. 5	1 ☐ Yes 2 🛣 No		r tiodri, etc.)	Specify:	ck, White, etc.
3 Widowed 4 Divorced Year or Dates. 1946	. Decedent's Usual Occup	ation _			White usiness Industry
3 Widowed 4 Divorced If Yes, Give 1943- Year or Dates. 1946 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done of life, DO NOT use retired)		ing	TOD. FAILE OF BE	23me33 madaliy
	Heavy Equipm	ent Opera	ator	Const	ruction
17. Father's Name (First, Middle, Last) Chafter Johnson Wooldridge		18. Mother's Name)
Sharter Johnson Woordridge	o. Mailing Address (Street a	Patsey	Hager		State Zin Codel
Marie Wooldridge - Wife	5804 43rd A				
20a. Method of Disposition 20b. Place of	of Disposition (Name of ery, crematory or other place		Date		- City or Town, State
TEL Bullar 2 - Olemation 5 - Hemovaritom State	incoln Cemet		2/2010	Bren	twood, MD
21. Signature of Funeral Service Licensee	22. Name and Addres	ss of Facility Ft	. Linco		ral Home, Inc.
23a. Part 1. Iter the disease, complicity in that caused the death. Do r		densburg		rentwoo	d, MD 20722 Approximate
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, 2-ling 15 immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of the conditions of the con	The stee	olim ut Fa Dise	ilune ase		Interval Between Onset and Death 2 4 h 3 weeks
d	h 3	ЭУ			ate of delivery onth Day Year
Part II. Other significant conditions contributing to death but not resulting i	in the underlying cause giv	ven in Part I.	- 1		ribute to the cause of death? 3 Probably 4 Unknown
91919			24a. Was		Were autopsy findings available
E C			autor perfo	rmed2	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examinar?	26. Pl	ace of Death (Check		40	
1 Yes 2 No 1 Inpatient 2 ER/Ou		4 ☐ Nursing Ho		dence 6 Othe	
27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) ii	Time of 28c. Injury work M 1 □		28d. Describe h	now injury occurre	ed
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	or investigation, in my opinio	on, death occurred at	the time, date a	and place, and due	e to the cause(s) and manner stated
29b. Signature and title of certifier	29c. License	966		29d. Date signed 9 / 2 7	d (Month, Day, Year)
30 Name and address of person who completed cause of death (Item 23a) (Takom	- Parle	m	P 24	0912
te 31. Oate filed (Month, Day, Year) 32. Registrar's Signature					

DHMH 17 Rev 7/2009

0-07579		Please Type or Print in Black Indelible	Ink. Ensu	re All Copie	s Are Le	aible.						
Robert S. Walls	Valls State of Maryland / Department of Health and Mental Hygiene											
		Registrar Certificate (of Death		R	eg. No. 2010	3230					
Physic					2. Date of Dea Month		3. Time of Death					
Medical Exam	iine	Robert Bearing, Warrs, St.			October 2	, 2010	0430 hrs					
		Facility Name (if not institution, give street and number) Easton Hospital	4b. City, Town, Easton	or Location of Death		4c. County of Deat	th					
Funeral		Social Security Number		I Killede OAT	lo n · · · · · ·	Talbot						
Director		January)	If Under 1 Y Months D	ear If Under 24Hrs, ays Hours Min.	1	Forei	rthplace (State or gn					
	ł	215-80-8022 1XM 2 F 42 Y	rs.		Aug.	l6 1968 c	ountry)Maryland					
any		10a. State 10b. County 10c. City, Town or Local	ation				10d. Inside City Limits					
nd show	⊾	Maryland Caroline Henderson					1 Yes 2 X No					
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code		11	0g. Citizen of What Cou	intry?					
death with the Maryland or items 23a or 28a-f sho must be notified at once.			21640			U.S.A.						
n with ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of I	lispanic Origin? (Spe	cify Yes or No		ican Indian, Black,					
death or ite	Ę	1 XNever Married 2 Married Armed Forces? If	Yes, specify Cub	an, Mexican, Puerto R	Rican, etc.)	White, etc.						
s after ral",	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2X N			Specify: Wh	ite					
hour "natu	te d	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) during r	nt's Usual Occup nost of working li	ation (Give kind of wo fe. DO NOT use retire	ork done ed)	16b. Kind of Business/	Industry					
36 hin 72 than dical	흴	t 12 machi	ne opera			manufactu	ring					
d with	Completed	17. Father's Name (First, Middle, Last)	ne opera	18.Mother's Name (I	First Middle M	ī						
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygies at a state it item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Be (Susan De								
21 nould id Mer is man	ပ		g Address (Stre	eet and Number or Ru	ral Route Num	ber, City or Town, State	, Zip Code)					
MD Id 2 sho lith and m 27 is					Goldsb	oro, MD 21	636					
ore, of Heal of Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or of	sition (Name of c ther place)	emetery,	Date	20c. Location - City or	Town, State					
Page ment tant: or ot		4 Donation 5 Other Specify: Denton Ce		Oct	6, 201	Denton,	Maryland					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiens Important: If item 71 is marked other than "natural", or items 22a or 28a-f she important: If item 71 is marked other than "natural", or items 22a or 28a-f she injury or other traumatic event, the Medical Examiner must be nofified at once		21. Signature of Funeral Service Licensee	Name and Addres	ss of Facility	ain Fun	eral Home,	DΛ					
	4 1	23a. Part I. Enter the disease, or complications that eaused the death. Do not enter the	Box 160). Greench	ara MD	21639						
Physician /M_di		failure. List only one cause on each line.	ne mode of dying	g, such as cardiac or r	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and					
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Lower Extremity Injury Due to (or as a consequence of):					Death					
. 100		Sequentially list conditions, b										
	ner	if any, leading to immediate Due to (or as a consequence of):										
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
executed an and al - transit		d										
ial ial	dical	UNPENDED AMENDED										
Box 68760, e death certificate be exc the attending physician ed for use as the burial	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 1	_		_	23d. Date of delivery						
certif	iğ.	past 12 months?	tal death 3	Ectopic pregnanc	у	Month D	ay Year					
~ ~ ~	ysi	1 Yes 2 No 9 Unknown 9 Unknown	her (Specify)			İ						
		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause	given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?					
signe be de	d by				1 Yes	2 No 3 Proba	ably 4 Unknown					
rds requ	Completed				24a. Was ar		opsy findings available					
ecc he lav ate has	틹	1			autopsy perform	ned? death?	ompletion of cause of					
Vital Records ysician: The law requi this certificate has been: director, page 2 should		25. Was case referred to medical		of Death (Check only		No 1 Yes	2 No					
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the ours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient		Other Nursing H		esidence 6 Other:						
of ing Pt After uneral	اۃ	27. Manner of Death 28a. Date of Injury 28b. Time of Ir	njury 28c. Inju			w injury occurred						
ion ttendi leath. tor:	[얆	1 Natural 5 Pending Oct 2, 2010 Oct 2, 201	1	Yes 2 ✔ No	issenger in	auto-fixed object	collision					
ivis lor A after of Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree	t, factory, office b	ouilding, etc. 28	f. Location (Str or Town, Sta	eet and Number or Rura	al Route Number, City					
Spital hours neral	ö	4 Homicide determined (Specify) Major Road / Highway 29a, Certifier			etree Road 8	Mudhill Road, Heno						
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the finneral director,	edical	229a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurr one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, de	ate and place, and due	e to the cause(s) and manner as stated	d.					
To t With To t	Med	and manner stated. 29b. Signature and title of certifier										
		Car	29c. Licens			29d. Date signed (Mont	n, Day, Year)					
	-	30 Name and address of pages the small delivery		····		October 3, 2010						
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn S	treet. Baltim	ore, MD 21201			-					
Sta	ate	31. Date file (CTh, Pay 4 2010 32. Registrar's Signature	1									
Regist	rar	API A & SOID MANAGE LA LA										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma			rtment of Ho			Re	g. N2 0	10	32305
18.	Physicia	an	1. Decedent's Name (First, Middle Sarah C. Sec		rman					Date of Death Month -27-2	Day	Year	3. Time of Death 2:28a M
	/Medic Examin		4a. Facility Name (If not institution, 11315 Homes	, give street and number)			4b. City, Town, or Big Po				4c. Count	y ol Death shing	
	Funeral Director		5. Social Security Number 213-16-1186	6. Sex 7. Ag	e (In yrs. last birth 95 y	rs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, 5-10-1	^{Year)} 915	Coui	place (State or Foreign http) cyland
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Wash	ington	10c. City, Town Big								10d. Inside City Limits 1 ☐ Yes 🌠 No
	3a or 28a-	i Director	10e. Street and Number 11315 Homes	tead Drive			10f. Zip Code 2171	1		10)g. Citizen of		ntry?
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f show entry injury or other traumatic event, I'm Medical Examiner must be notified at an once.	Completed by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1 Tyes 27 If Yes, Giver Year or Dates:			Vas Decedent of His Yes, specify Cubar ☐ Yes 2 X No	spanic Origin, Mexican, Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)		ck, White,	
21215-0036	within 72 ho lene. r than "natur r medical	ompleted	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th grade	's Education t grade completed) College (1-4or 5		(Give k life. D	ent's Usual Occupa kind of work done d NOT use retired; teacher	u <i>ring</i> most o	of working	The state of the s	Schoo		ndustry Ystem
Maryland 2	uld be filed v Aental Hygie rked other it tic event, E	To Be C	17. Father's Name (First, Middle, Elmer Dani						s Name (Fi	Snyc		me)	
, Mary	s 1 and 2 show of Health and M item 27 le ma other trauma		19a. Informant's Name/Relationsh Shielda M.S		e 11	115	g Address (Street a 4 Big P	nd Number	Rd.B	ig Poo	ol, MI	21	711
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition Burial 2 Cremation 4 Donation Other (S)	3 □Removal from State		r, crem Pau	atory or other place 1 Cemet	ery	Oct. 201(,		r Spi	ring MD
Ball	Dermit. Depart Import eny in		21. Signature of Fundal Service 23a. Parti. Enter the disease, or shock, or heart failure. List		R	DC P	Name and Address nald Ed O.BOX 3	s of Facility Win 10 C	Thomp lear	oson I Sprin	Tunera	al Ho	ome,Inc
	Physician /Medical Examiner		23a. Parth. Enter the disease, or shighck, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Conor	a consequence o	Hec	urt Fall	ure	artifac of re	sspiratory arre		1	Interval Between Onset and Death
760,	te be executed ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiliated events resulting in death) Last	C	a consequence o								
P.O. Box 68	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, oulcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	NII	Α			ate of delivionth	very Day Year
	quires that n signed b uld be deta	2	Part II. Other significant condition Hyper tens		out not resulting in	the un	derlying cause give	en in Part I.			oacco use co	ntribute lo 3 ☐ Pro	the cause of death?
Division of Vital Records,	itcian: The law requir certificate has been si rector, page 2 should i	Completed	Diabetes	mellitus	5				_	24a. Was a autops perform	n 24b y ned? 2 No	. Were aut prior to death? 1 \(\sum \) Yes	copsy lindings available ompletion of cause of
Vita	Physician: rthis certificant	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpali	ent 2 ER/Out	nation	t 3□ DOA Oth	200	ol Death (C	5 Reside	e) ance 6 □O	ther (Spec	u(v)
on of	Attending Phy rideath. ector: After this by the funeral d	tion: To	27. Manner ol Death 1 Natural 5 Pendin 2 Accident investig	28a. Dale of Inju		_	28c. Injun Work		280	I. Describe ho			
Divis	al or Atter s after dea il Director od in by the	Certification:	3 Suicide 6 Could determ	ined 200. Place of the	jury - At home, far tc. (Specify)	m, stre	eet, factory, office		281	Location (St City or Town		nber or Ru	ral Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the best Examiner: On the basis of and manner st	of my knowledge of examination and ated.	, death Dor inv			d place, and h occurred				
	To the within 2 To the comple	M	29b. Signature and title of certifie	X Q	Ju	<u></u>	29c. Licens	o number			9d. Date sign		n. Day, Year)
ئ	H-20		30. Name and address of person Joseph Asunci					Suite	107	Hoojers	town r	nd a	21742
7	Sta Regist		31. Date liled (Month, Day, Year)		rar's Signature		ad						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2.200M E Medical 4a. Facility Name (if not institution, give street and number, 4b City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake-Mandrin House Anne Arundel Annapolis Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Min. May 9, 1918 Maryland 92 Director 215-16-0405 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoe. 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Randallstown Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3801 Schnaper Drive 21133 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 ☐ No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Year or Dates WWII 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Adm. Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frances Falise Joseph Brocato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Amber Orchard Ct. W. #202 Odenton, MD 21113 wife Mrs. Katie L. Brocato 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard. 10/19/10 Finksburg, Maryland . Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME 21136 Reisterstown, MD 23a. Part 1. If ter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 month Month Day Year signed by the a Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 4 Unknown 1 Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Eertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month. Dav. Year) 118703 10/13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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DECENSE HWY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		cate of Death	Reg.	No.	32301
Physici		Decedent's Name (First, Middle,Last)	00 11 0	5 - 20 \	2. Date of Death Month D	av Year	3. Time of Death
Medical Exam	iner	4a. Facility Name (if not institution, give st	11011	wrney	September 1	16, 2010	0041 hrs
		5620 Marlboro Pike	eet and number)	4b. City, Town, or Location of Dea District Heights	atri	4c. County of Death Prince George	's
Funeral		Social Security Number	7. Age (In yrs. last b		Irs. 8. Date of Birth(MM/DD/YYYY) 9. Birtl	hplace (State or A
Director		5798 0722 10M	2□F 35	Yrs. Months Days Hours M	In. 8/2/	1	intry) Or wi757
_		Usual Residence of Decedent				(1)	~~
w any		10a. State 10b. County	10c. City, Tov	n or Location			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor	10s Street and Number	W	201 Notponde			1 Fes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	-2 ()()	10x_2p Code	10g.	Citizen of What Coun	try?
5-0036 led within 72 hours after death with the Maryland dygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	eral [11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	ean Indian Black
leath v r item	Fune	1 Never Married 2 Married 1	Armed Forces? Yes 2 No	If Yes, specify Cuban, Mexican, Puer		White, etc.	arrindari, black,
after call, on	by F	3 Widowed 4 Divorced If Y	es, Give Year Dates:	1 Yes 2 No specify:		Specify:	ACK
hours natur Exam	edt	15. Decedent's Education (Specify only h		 Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use n 		6b. Kind of Business/In	dustry
36 iin 72 han " dical]	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)	contact 11 ac	Vo	D . 11/1	10
5-0036 led within 7 tygiene. other than	Completed	17. Father's Name (First, Middle, Last)		SANITATION CON	ne (First, Middle, Mai	den Surname)	10
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (William ANTA	12M BUCH	end Sh	1 hora	MANNIN	09
21 hould of Mei is man	2	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street and Number o	r Rural Route Numbe		ode)
MD and 2 sh salth and 27 is		Sharon Mitna 20a, Method of Disposition	Jing/Mother	e of Disposition (Name of cemetery,		Oc. Location - City or T	1 6000
imore, MD ? Pages 1 and 2 shounent of Health and 1 inem 27 is unoughtern if item 27 is unoughtern traumatic		1 Burial 2 Cremation 3	Removal from State	atory or other place)	Date	Sc. Location - City or 1	own, state
		4 Donation 5 Other Specify: 21. Signature of Funeral Service Idensee	1/197	22. Name and Address of Facility		100 +	MID
Balt permit. Depart Impor injury		Writer	allo	1425 MANAN	10 ALRE A	LE CAR	h glow
Physician		23a. Part I. Enter the disease, or complicat failure. List only one cause on each li		not enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Appro_imate Interval Between Onset and
Me dic al Examiner		Immediate Cause (Final disease a. Mu	tiple Injuries				Death
1		h	to (or as a consequence of):				
	ē		to (or as a consequence of):				
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):			- 22	
na se di con	Exa	d.					
760, cate be execut physician and the burial - tra	Medical	UNPENDED A	MENDED				
760, Teate be		IF FEMALE: 2 23b. Was decedent pregnant in the	3c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 687 e death certific the attending of for use as the	cian	past 12 months?	Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pregr5 Other (Specify)	nancy	Month Da	ay Year
Box 687 ne death certific r the attending I	Physician/	1 Yes 2 No 9 Unknown 9	Unknown	Other (speak)			
P.O.	by P	Part II. Other significant conditions con	tributing to death but not resulting	ng in the underlying cause given in Part I.		cco use contribute to th	
S, P.C juires that en signed l	edt	-				No 3 Proba	
ords, aw requir	ple				24a Was an autopsy performed	prior to co	ppsy findings available mpletion of cause of
tal Rec	Completed					No 1 ✓ Yes	2 No
ital iician: s certi	Be	25. Was case referred to medical examiner?	tal: 1 Inpatient 2 ER/0	26.Place of Death (Check Outpatient 3 DOA Other, Nurs		sidence 6 🗸 Other:	P
n of Vi ling Physi After this funeral di	£.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d. Describe how		Scerie
on on ath.	ţi	1 Natural 5 Pending	Sep 16, 2010 000	1 Yes 2 ✓ No	Passenger auto fixed object	o auto collision, t	hen struck a
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fine of the funeral director.	ifica	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Stree	et and Number or Rura	I Route Number, City
Di spital spital spital filled	Certification:	4 Homicide determined	(Specify) Local Street		or Town, State 6620 Marlboro Pi	ke, District Heights,	MD
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.				eath occurred at the time, date and place, an investigation, in my opinion, death occurred			
To t with To t	Medical	29b. Signature and title of certifier	manner stated.	29c. License number		od. Date signed (Monti	
		my his, w	O	O.C.M.E.		eptember 16, 20	
	-	30. Name and address of person who comp					
\			,	n Street, Baltimore, MD 21201			
St Regist		31. Date filed (Month, Day, Year) OCT 1 5 2010	32. Registrar's Signature				
Regist	LC I	WOI I VIOLU (Page	un a sank	V			

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			Please Type or Pri	aryland / Dep	partment of F	lealth and M		•	0.0000	
	Physici		1. Decedent's Name (First, Middle, Last) YELIK BITMAN	Ce	ertificate of	Death	2. Date of Death Month OCF	Day Year	3/3/8 3. Time of Death 6:00 A M	
?	/Medic Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME	ge (In yrs. last birthda 74 Yrs.	BALT	Location of Death LOCATION TO THE LOCATION TO	8. Date of Birth (137/12 6 ay 1	4c. County of Dea		
	Director tiffed at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE						10d. Inside City Limits 1 Yes 2 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 3615 FORDS LANE, #615 11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13	10f. Zip Code 2 3. Was Decedent of H If Yes, specity Cub.	1215 ispanic Origin? (Spe		USA	14. Race - American Indian,	
5-0036	72 hours after natural", or It	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed)	No 16a. Dec	1 ☐ Yes 2 ☐ No	Specify:	1		HITE	
Maryland 21215-0036	be filed within 72 h al Hygiene. I other than "natu went, the Medi al	Be Completed	Elementary/Secondary (0-12) College (1-4or 12) 17. Father's Name (<i>First, Middle, Last</i>)	life	TRUCK DRI	1)		FOOD DELI	VERY	
Marylar	d 2 should be th and Menta ?7 is marked traumatic ev	ToB	EFIM BITMAN 19a. Informant's Name/Relationship (Type. Print) ZELDA BITMAN / WIFE		iling Address (Street		I Route Number,	KORETSKAY City or Town, State,	Zip Code)	
Baltimore,	. Pages 1 an ment of Heal tant: If item 2 jury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dis cemetery, ci	position (Name of rematory or other plac RE HEBREW	CEM 10/14	/2010	0c. Location - City o	r Town, State	
Ball	permit Depart Import any In		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each i		22. Name and Addre	TERSTOWN	ROAD PI	ON & BROS KESVILLE,	MD 21208 Approximate	
Tool No.	Physician /Medical Examiner	16	Immediate Cause (Final disease or condition resulting in death) a. Acut Due to (or as	te rena	1 6 1	ure			Interval Between Onset and Death I 4 days > 6 months	
68760,	ate be executed hysician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):	,					
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	v requires that been signed b should be deta	eted by PI	Part II. Other significant conditions contributing to death t		anderlying cause giv	en in Part I.		s 2 □ No 3 💢 F	to the cause of death? Probably 4 Unknown autopsy findings available	
'ital Re	The larate has	Be Compl	25. Was case referred to medical examiner?	4 9150	4154	26. Place of Death	autopsy perform 1∐ Yes 2	prior to death? 1 □ Ye	completion of cause of	
Division or Vital Records,		은	27. Manner of Death 1 Natural 5 Pending 2 Accident Rospital: 1 Inpati	ent 2 ER/Outpati ury 28b. Time ay Year) Injury	of 28c. Injury	y at	me 5 Resider 28d. Describe how	nce 6 □Other (Sp. w injury occurred	ecify)	
Divis	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Il Certification:		jury - At home, farm, stc. (Specify)			City or Town,			
	To the Hos within 24 ho To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis and manners 29b. Signature and title of certifier	ate and place, and duted. Date signed (Mor	ne to the cause(s) nth, Day, Year)					
7			30. Name and address of person who completed cause of a 2434 W BELVEDE (31. Date filed (Month, Day, Year) 32. Regist	death (Item 23a) (Typ R A V E	e, Print) SUR NUE, BI	AIYA B ALTIMORI	ELLUM, E, MD.	MD - 21215	_	
V DH	Sta Registi MH 17 Rev 1/2	rar		A. Jan	le)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Ravth. een /Medical October 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 1 F Director 215-01-9030 93 4. 1917 Maryland Feb. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane RGS120 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Railroad Clerk Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James E. Kane Alice Russell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Barth Son 8734 Timber Oak Lane; Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery | 10/16/2010 | 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Servi a Littens e 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Small Due to (or as a consequence of): ston Canco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed page 2 completely filled in by the funeral director,

Physician /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Certification: To

			24a. Was an autopsy performed? death? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No									
25. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner → Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury	Injury at Work? 280	d. Describe how injury occurred									
3 Suicide 6 Could not be 4 Homicide determined		fice 28f	f. Location (Street and Number or Rural Route Number, City or Town, State)									
	hysician: To the best of my knowledge, death occurred at t iminer: On the basis of examination and/or investigation, in and manner stated											

29c. License number

29d. Date signed (Month, Day, Year)

10

20228

hin 24 hours after death the Funeral Director: Hospital

2

or Attending Physician:

State Registrar

Medical

31. Date filed (Month, Day, 5 2010

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Clanton Day Year **Physician** James 14:05 October 2010 13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) 1X□M 2 □ F Days 83 246-36-9503 6-9-1927 N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 ☐ No Baltimore na 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Bond Street 1728 N. Funeral 21213 U S Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Yes 2 [If Yes, Give Year or Dates 1 Never Married 2 X Married 2 No 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Clanton Blanch West ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. Clanton-Wife 1728 N. Bond Street Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State 10-19-10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final endocarditi s disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗀 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No ၉ 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

/Medical Examiner To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

attending physician I for use as the buri þ page 2 should Director; After this d in by the funeral filled in by within 24 hours at

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Funeral

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items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examiner eney.

Physician

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

death with the Maryland

let1 State

Medical

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2010

ocrober

600 North Wolfe St, Baltimore, MD, 21287

Cappelli Laura 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1220 PM Bonnie Lee Como 2010 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore 8. Date of Birth
(Month, Day, Year)
June 1,1953 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Days Hours Maryland Months 1 □ M 2 ⋤ F 220-62-3835 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Eventiner rust be notified at 1 ☐ Yes 2X No Director Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 4403 Bronzewing Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give^X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White jo, Specify: ģ 3 ☐ Widowed 4 ☐ Divorced is marked other than "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Office Manager Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Rae Head Charles R. Hummel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. of Health 4403 Bronzewing Court Nottingham, Md. 21236 Michael D. Como 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 10-16-2010 Parkville, Md. Parkwood 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Nottingham, Md.21236 Approximate Interval Between Onset and Death Metastatic Ademocarcinona 3weeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) detached 9 🗀 Unknown reare nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate | 2 **N**o 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check enly one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D45390 October 12th. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MYO MIN (N.D.) 9114 | Philadelphia Road # 208, Baltimore, MD 21237 31. Date filed (Month, Day, Year) State Registrar

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			Registrar 1. Decedent's Name	(First Middle La	et)			erui	icale of	Deall	/	2. Date of D	Reg. N	lo.	LU_	3. Time of	Death
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	Funeral Director		5. Social Security Nu 579–12–10	4	ex □M 2□F	7. Age (/n)	yrs. last birthd 7 Yrs	"/ M	f Under 1 Year Ionths Days	Hours	Min.	8. Date of B (Month, D March	irth ay, Yea 1,	r) 1923	Coun	lace (State or try) ningto:	
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0500-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Marrie 3 □ Widowed 4		1 Yes If Yes, Giv Year or D	2□ No ve V	WII		lYes 2√ENo			, , , , , , , , , , , , , , , , , , , ,		Specify:		ite	
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5	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregr 9□Unkn	nant at time own	of death	5 🗆 O	ther (specify) _					NOI	itti	Day Y	eai
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INISIOI	pptral or Attending Physician: The law ours after death. eral Director: After this certificate has filled in by the funeral director, page 2 s	Certification:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		of Injury th, Day Yea	28b. Tim		28c. Inju Wo M 1	iry at vrk?] Yes 2 [28d. Describe	how in	jury occurre	ed		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registraramend 1 per 'Dr. g908 10/15/16 ertificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 8 1:15 PM Nathaniel Cole 2010 /Medical 4c. County of Death Facility Name (If not institution give street and numb 4b. City, Town, or Location of Death Examiner more Medical Ba Cer ex more Baltimor Kod If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 □ F ME NOURY ISSUED AUGUST 10,2010 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any jujury or other traumatic event, I'm Mutical Evaminar must be notified at once. 1 ☐Yes 2 No WINDER MILL Director BALTIMORE ME 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7214 7201 OAKHAVEN CR. USA 212316 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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FINE FUNERAL HOME P.A. 426 CEAIN NEW SW GIEN BURNIE MD 21061 CREGOZY FINK BUILDIN Approximate Interval Between Onset and Death 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home Hospital: Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DDA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier DOO60255 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A SH 406 Towson MD 21204 31. Date filed (A State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death octoter 1:17PM erabline **Physician** 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year)
Jan.14,1948 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months 1 - M 2 XF Days Hours Va 215-46-9455 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show 1 TXYes 2 □ No 3a or 28a-f sl Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 23a 1750 Homestead 21218 St. USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?

1 Yes Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 21215-0036 ö 1 Yes 2 No Specify Specify: Black If Yes, Give Year or Dates: ģ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) er than "natur, the Medical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Factory Worker First Brother Co. llth other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be marked Fannie Vaughan Preston Winkler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Homestead St. Baltimore, Md 21218 Walter D. Melton, Jr/son 1750 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State ArbutusMem.Park Oct.21,2010Balto.MD 4 Donation 5 Other (Specify 22. Name and Address of Facility 21. Signature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD

Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Pan 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. CITTAGSIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed do Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 \sum Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 Residence 1 Yes Certification: To Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. the Hospital

> State Registrar

31. Date filed (Month, Day, Year) 15 2010

on

29b. Signature and title of certifier

29a. Certifier

Medical

32. Registrat's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

29c. License number

RES-000

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene.	al", or iten Examiner r	ρ	11. Marital Status 1 Never Marri 3 Widowed		ried 1 L	Decedent ed Forces? Yes 2 2 es, Give r or Dates.	Ever in U.S		Was Dece If Yes, spe 1 Yes				ify Yes or No- ican, etc.)	-	14. Race - Black, Specify:	White, et		
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68760 sertificate br	ding p	/Me	IF FEMALE: 23b. Was decedent	prognant	23c. If ye	es, outcome	e of pregna	ncy							23d. Date	of deliver	~	
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Division all or Attendir	Il Directo	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	: [28e.	Place of In building, et		me, farm, st	treet, facto	ry, office		2	8f. Location (City or To			or Rural F	Route Number,	
ALEEN DATES 10 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	ne Funer.	Medical	(Check 2	☐ Medical E	Physician: To xaminer: On the Nurse Fraction	he basis of	examination	and/or inve	stigation, in	my opinio	on, death or	ccurred at t	he time, date	and place	e, and due to	o the caus	se(s) and manne	er stated.
70 th	10 € 00 E 00 E 00 E 00 E 00 E 00 E 00 E		29b. Signature and t	title of certifier					29	c. License	number			29d. Da	Date signed (Month, Day, Year)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32316 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ oftober 14, 2018 7:05 A M Esther R. Ermer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 0270471909 Wisconsin 101 **Director** 397 46 7041 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Rockville Montgomery Maryland 1 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 20850 U.S.A. 9701 Veirs Drive permit. Page 1 and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3XXWidowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Nass Albert Proefrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Hopkins Landing Drive, Essex, Maryland 21221 Lois M. Nehmer (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🏿 Removal from State cemetery, crematory or other place) 10/18/2010 Milwaukee, Wisconsin 4 Donation 5 Other (Specify) Pine Lawn Cemetery 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 old Fastern Avenue, Essex, Maryland 21221 Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the deat. Do not enter the mode of dylor, such as cardiac or re-piratory arrest, shock, or heart failure. List only one cause seach in e. Approximate Interval Between Immediate Cause (Final Onserrand Rooth 'yuician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence on Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical

Be Completed မြ Certificate: To the Hospital or Autorians, within 24 hours after death.

To the Funeral Director: Aft

certificate

this

After t

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of de Month	elivery Day	Year
art II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to		
		24a. Was an autopsy performed?	death?	utopsy findin completion s 2 \(\subseteq \text{No}	of cause of
. Was case referred to medical	26. Place of Death (Check o	nly one)			
examiner?	Hospital: Other:				

1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State,

ſ	29a. Certifier 1 Certifying Physician: To the best of my knowl	ledge, death occured at the time, date and place, and du	e to the cause(s) and manner as stated.
1	(Check Medical Examiner: On the basis of examination	n and/or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s) and manner state
١	only one) 3 Certifying Nurse Practioner: To the best of my	y knowledge, death occurred at the time, date and place, ar	nd due to the cause(s) and manner as stated.
ĺ	29b/Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Į	(Lealer (0) have	sh- D21726	October 14, 2010

ler (D.A 30. Name and address of person who completed cause of death (Item 23a) (Type,

Charles Karesh, 9701 Veirs Drive, Rockville, Maryland 20850

State Registrar

Medical

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 4a per doc g908 10-15-10 vt
State of Maryland / Department of Health and Mental Hygiene
AMEND THEM 12, 20a-c, per FH, G908, 10/21/2010, WS
Certificate of Death Reg. No. 2 0 | 0 For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year AM JR mes ALBer 2010 october Medical 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SON 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours Min. 1 **X**M 2 □ F Months 264-16-4859 Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a, State 10b. County be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director BALTIMORE 1 XYes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 items 23a BELMONT U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever III.

Armed Forces?

1 X Yes 2 No 1942/

Year or Dates. 10/1942/

Year or Dates. 10/1945 Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SALESMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is manany injury or other? ၉ ALBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🐊 //// FINIEY MONKTON, MARY IAND 20b. Place of Disposition (Name of 20a. Method of Disposition Jate 20c. Location - City of Town, State 10/22/2010 Baltimore, Maryland Balt Pinore Nate 1 Cemetery Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Th & Jure of Funeral Service Licent DERRICK · JONES FIH, PH 4611 PARIX HOTS. AUE., BALTIMURE, Md, 21215 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ons. d ath Immediate Cause (Final ^onysiciam state an disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions ņ if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 1% months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day ☐ Pregnant at time of death☐ Unknown g Unknown eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy perform death? 1 🗌 Yes 2 No ___ Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 No Accident Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined hours after City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an Hitle of certifie 29d. Date signed (Month, Day, Year) 0 son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G908 10/22/10 JH/#6perFH G908 10/22/2010, WS State of Maryland Department of Health and Mental Hygiene For State Registrar Reg. Ne Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 10 Day | Physician/ eldS 1:00 AM Medical Facility Name (if not institution, give street and number) or Location of Death Examiner 4c. County of Death university of Maryland Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth Funeral Min 1 X M 1 Month of Mary Land Director 217-56-8008 56 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho appropriant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amount in into yor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore ME 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 Eager St. Apt#417 U.S.A. 1517 E. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 2 Years Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lillian F. Sherrod James Robert Fields Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Mt. Holly Street, Baltimore, MD 21229 Lillian Fields (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date JosephreBrowner FOH And Crematory 1 Burial 2 Kremation 3 Removal from State 10/12/10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ²²Josephi^{dre}H. Fabrown Jr. Funeral Home PA unn 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or it that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death been signed by the the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24á. Was an after death.

Director: After this certificate has t autopsy 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 101 2010 30. Name and address of person who completed cause of death (Item 23) #ype, Print) Catherine Clements 21201 Street Himere, MO aceen. 31. Date filed (Month, Day, Year) 32. Be State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Howard B. Fosler, Jr. 7:30 PM 2010 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dak Crest Village Baltimore County 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) Country) Maryland Davs Hours Director 212-03-5390 95 September Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must <u>be notified at</u> 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 1402 Waldon Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Baltimore County Board Elementary/Seconday (0-12) College (1-4 or 5+) Administrator of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be file ment of Health and Mental I tant; If item 27 is marked α Hattie I. Herpick Howard B. Fosler, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 20815 #104 Woodbine Street Chevy Chase, Maryland Scott Fosler Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Metro Crematory 4 Donation 5 Other (Specify) October 13,2010 Baltimore, Maryland Sanature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Baltimore, Maryland 7401 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementia 2 No 3 Probably 4 Unknown Records, ortery diseise 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy or Attending Physician: VS C ivision of Vital Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident 3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my included, Seath occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1ther Blvd, Parkville, MD 21234 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

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William Joseph	Goi	Tato of Maryland / Boparanont of Health and Me	ental Hy	giene	•	2010	22226
		1- For State Certificate of Death		R	eg. No.	2010	32320
Physicia Medical Exami	an/ ner	1. Decedent's Name (First, Middle, Last) WILLIAM JOSEPH GOINES, Jr.		2. Date of Dea Month October 3	Day	Year 0	3. Time of Death 0435 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locatio Frederick Memorial Hospital Frederick	n of Death			. County of Death rederick	
Funeral			ider 24Hrs	8 Date of Ric		DD/YYYY) 9. Bir	tholace (State or
Director		2/3-04-5546 1/M 2/F 30 Yrs. Months Days Hou				Foreig	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
*	ō	MD. FREDERICK FREDERICK					1 Yes 2 No
and 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygene. ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 50 VIENNA (T. 21702	,	1	_	zen of What Cour	ntry?
th with tems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O 1 Never Married 2 Married Armed Forces? 15 Married 17 Married 18 Married 19 Married	rigin? (Spe	ecify Yes or No	-	14. Race - Ameri White, etc.	can Indian, Black,
after des	by Fur	3 Widowed 4 Divorced If Yes, Give Year or Dates:		,,	i	Specify: BL	ACK
natura		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Given	e kind of wo	ork done	16b. K	ind of Business/I	ndustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) LABOR	i use retire	oa)	C	ONSTR	UCTION
5-0(Hygie other			er's Name (First, Middle, M	Maiden :	Surname)	_
121 d be fi ental arked	B			SIM			
MD 2 12 shoul th and M 127 is m umatic	잍	19a. Informant's Name/Relationship (Type, Print) WILLIAM J. GOINES SR. (FATH) 50 VIENNACT (imber or Ru FRED (ral Route Num	nber, Cit	y or Town, State,	Zip Code)
ore, ME ges 1 and 2 s of Health as If item 27 ther traums		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. L	ocation - City or	Town, State
Page Page nent o	- 1	4 Donation 5 Other Specify: AIRVIEW COM.	007.8	2010	FR	EDGRIC	RMB.
Baltimore, permit. Pages 1 as Department of Hes Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ty6AX	YL. A	OCC	INS PUR	1. Ifone
Physician	1	23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as	cardiac or r	espiratory arre	est, shoc	ck, or heart	Approximate Interval
/Medical Examiner	ł	failule. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Abdomen					Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.					·
	٥I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
xecuted n and l - transit		events resulting in death) Last Due to (or as a consequence of):					
	la lei	UNPENDED AMENDED					
760 cate b	Š,	IF FEMALE: 23c. If yes, outcome of pregnancy			23d.	Date of delivery	
Sox 68760, leath certificate be ex e attending physician for use as the burial -	Physician/Medi	Pregnant at time of death	ic pregnanc	У	1	Month Da	y Year
Box death	ysi	1 Yes 2 No 9 Unknown Other (Specify)			1		
ires that the des signed by the a lbe detached for	a S	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	art I.	23e. Did tob	pacco us	se contribute to th	e cause of death?
S, P uires th n signe d be d				1 Yes	2	No 3 Proba	bly 4 Unknown
ord w req as bee	E E			24a. Was a autops			psy findings available mpletion of cause of
tal Records, cian: The law requii certificate has been sector, page 2 should	Completed			perform		death? 1 ✓ Yes	2 No
ician: The certificate rector, page	8 . °	25. Was case referred to medical examiner? Hospital: 1 Inaction: 2 Inaction:	_				
of Viting Physical After this	의	examiner/ 1 Ves 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other4 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work		dome 5 R		ce 6 Other:	
ion of tending Pheath.		1 Natural 5 Pending FOUND: FOUND: 1 Yes 2	بكا ،	bjectt shot		occurred	
VISIC or Atte ter des virecto	lg Liga	2 Accident Investigation Oct 3, 2010 0330 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et	-	f. Location (St	reet and	Number or Rura	I Route Number, City
Divis pital or At ours after d eral Direct filled in by	린	4 Momicide determined (Specify) Found, Local Street	Fo	or Town, Sta und, 200 Bio		Madison St., Fre	ederick, MD
	ह्य	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	ace, and du curred at th	e to the cause le time, date al	(s) and a	manner as stated e, and due to the	cause(s)
F. 8 F. 8	8 2	29b. Signature and title of certifier 29c. License number			29d. Da	ate signed (Mont)	n, Day, Year)
		Chef Hallan O.C.M.E.			Octob	per 3, 2010	
21	3	30. Name and address of person who completed cause of death (Item 23a)			-		
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201				
Sta Registra	_	11. Date filed (Month, Day, Year) 32. Residue Signature					
DHMH 17 Rev 1/200		ORIGINAL			_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ORDON October 2010° 1:00 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Villa Nursing Home **Baltimore** Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Dec . | 28 , Social Security Number 6. Sex **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2XX Maryland Director 217-09-7778 93 Dec. 1916 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 XNo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? Funeral 711 Academy Road 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural" Completed 3 XWidowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Grade Salesperson Food&Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Fink, Sr. Matilda Ernestine Griffner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Fink/Brother 9638 Oak Summit Avenue Baltimore MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other place) injury (4 Donation 5 Other (Specify) Atlantic Crematory Oct. 12, 2010 Glen Burnie 21. Signature of Fyneral Service License ^{22. Name and Address of Facility}1 Funeral Home, Miller-Dippel Funeral Home, 6415 Belair Road Baltimore 21206 23a. Part 1. Enter the disea shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dust to for as a nonsequence or, the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 - No 1 Tyes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 2 ☐ Acciden 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature_a 29c. License number who completed cause of death (Item 23a) (Type, Print) Name and address of persor TURAICHIA 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene	2010	32322
Certificate of Death		

		1- For State Certificate of Death Reg. No.	
Physicia Medical Exami		Definis Gaulette Month Day Year October 4, 2010 1424 hrs	1
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore City	
Funeral Director		5 Social Security Number 156-24-8348 6. Sex 17. Age (In yrs. last birthday) 6. Sex 1948 6.	
Maryland 28a-f show any d.atonce.	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City I 1 Yes 2 X	
the Mary 3a or 28a- otified at	Director	10e. Street and Number 623 Maple Hill Lane 10f. Zip Code 21032 10g. Citizen of What Country? USA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 3 Widowed 4 Divorced ITYes, Give Year 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: Specify: Specify: White	
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unkn.	
hou hou is n di	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chistopher Heer/Friend 11114 Willow Bottom Drive, Columbia, MD	- 73
ore, ME		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 20c. Location - City or Town, State	
Page lent cent		4 Donation 5 Other Specify: Final Journey Crem 10/13/10 Woodbine, MD	
Balti permit. Departm Imports injury o		21. Signature of Funeral Service Hospise Dorota Marshall 22. Name and Address of Facility Cremation Services Maryland Cremation Services PO Box 1413, Baltimore, MD 21203	
Physician Madical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease Appertensive Atherosclerotic Cardiovascular Disease Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):	
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ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed asth. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	
P.O. Bost that the degree by the detached f	죕	Part II. Other significant conditions < contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	1?
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Division of Vital Records, Isla or Attending Physician: The law requir us after death. ral Director: After this certificate has been so lied in by the funeral director, page 2 should the control of th	omple	autopsy prior to completion of cause performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
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Division of piral or Attending Plours after death. eral Director: After ifilled in by the funeral	Catio	Natural 5 Pending 1 Yes 2 No	City
1/2 2 3 2 4 1	Certification:	Suicide Could not be determined (Specify) 4 Homicide (Specify)	,
4 등 4 등	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To To Con	\$	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 5, 2010	
O pend		30. Name and address of person who compilete cause of death (Item 23a)	
77		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar Signatule	
St Regist			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# I per PHYS, G908, 107 157 2010, WS

State of Maryland / Department of Health and Mental Hygiene. For State Registrar 32323 Certificate of Death 1. Decedent's Name (First, Middle, Last) Clevand L. Horton, Sr. 2. Date of Death 3. Time of Death Physician/ ctobe TOV 1504M Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Dec more wes 6 6. Sex 1 M 2 D F Year If Under 24 Hrs. Days Hours Min. Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month, Day, Year) Country) Director 216-50-2051 Yrs N.C. -24-1948 Usual Residence of Decedent 28a-f shov 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside Cify Limits Director must be notified MD Baltimore na 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5937 Daywalt Avenue 21206 USA items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner o. by 1 Never Married 2 Married 1 Yes 2 No Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Specify: Black Completed ed wn. ral Hygiene. rher than "nav. ه Medical Ey Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) lementary/Seconday (0-12) Entrepreneur College (1-4 or 5+) Business Owner æ pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F မ Luther Snipes Arlelia Horton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5937 Daywalt Avenue Peggy Horton-Wife Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vet 10-18-2010 Prince Geo Co, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final disease or condition Onset and Death Enysician, 10 Va Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d, Describe how injury occurred injury Natural Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifi 201C address of person who comple cause of death (Item 23a) (Type, Print) cla MK 31. Date filed (Month, Day, Year) State 5 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hall 2010 4:25 PM Robert October Medical Wayne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sparrows Point
If Under 1 Year | If Under 24 Hrs. 2825 Lodge Farm Road Apt#_230 Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 🔀 M 2 🗆 F . Date of Birth (Month, Day, Year) 11/13/1944 Director 218-42-9813 Virginia or 28a-f show 10a. State 10b County 10c. City Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 Lodge Farm Road Apt# 230 21219 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) aborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Hall, Ethel Agnes Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Barbara Jean Hall (Sister-in-Law) 721 Kingston Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Liter the limit ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition relating in death)

a. Due to (or as a consequence of Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any Leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes, CAD, atrial fibrillation, CKP, 1 Des 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 **Division of Vital**

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Gastern

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 22 2010 5 45 P M Ruth B Haynesworth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Min. 1 M 2 Z F 88 214-36-0666 MD **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours arter ucea......
if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show
item 27 is marked other than "dedical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD FREDERICK FREDERICK ✓ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 EVERGREEN COURT Funeral 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2 No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Montal Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Qollege (1-4 or 5+) TEACHER 64V9 SCHOOL BOARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bowie CORA DIGGS WALTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAW) MANDA NAYLOR PREDBEICE 101 tubrighten of 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthauen Mem. Gue 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Soot 282010 FREDERICA MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ARY L. ROLLINS RWEAR HOME 21. Signature of Funeral Service Licensee olling my x 110 WEST SOUTH STFREDERICK MO 21701 23a. Part 1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he an failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner MONITHS. Dem entia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and -transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) physician sthe burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ဂ္ 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28h Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending nours after death.

neral Director: Aff 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 00062223 9/23/2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 196 TJ DRIVE, SUITE # 135 4702

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar 32326 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:05 A M October 2010 Henry Edward Hubbe, Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F **Funeral** Days Months Hours Min Country) Maryland Director 214-22-4034 1928 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 10a State with the Maryland Director 1 ☐ Yes 2 🂢 No Harford Jarrettsville Md. 10f, Zip Code P 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 1913 Belle Guard Drive 21084 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Yes 2 No ō þ 1 Never Married 2 Married Marylahd 21215-0036 1 Yes 2 No Specify White 11 1es, Give Year or Dates. 1950—1952 Specify "natural", 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Overhead Lineman BG &E Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry E. Hubbe, Sr. Marie Pauline Leonora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jarrettsville, Md. 21084 1913 Belle Guard Drive Richard Hubbe Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 0 - 16 - 2010Balto. Md. Oaklawn Cemetery Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Schimunek Funeral Home 22. Name and Address of Facility auro 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) nous Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 第00 39 3 名 4 4 Division of Vital Recdrds, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tery descase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed MC 1 Yes 2 No フセ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Other: 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Certificate: injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No Director: Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined hours after within 24 hours a ledical 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number D0053568 October 11. 2010 500 Upper Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T land HOMPSON MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 32327 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D Year 70 Physician/ 06 AM Margaret Hyden F Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Medica University of Maryland 8. Date of Birth (Month, Day, Year) Oct 16, Birthplace (State or Foreign Country) Funeral Min Months 1 🗆 M 2 🗶 F Hours 1950 Maryland Director 212-58-8106 Usual Residence of Decedent 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 666 Sprite Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 2 X No <u>۾</u> Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F. ပ Catherine Dolores Bury Francis Xavier Fainter traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Hyden /Husband 666 Sprite Way Glen Burnie, MD 21061 Carl Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) 2010 Chesapeake Crematory 21. Signarule of Funeral Service Licenses 22. Narce and Adversor Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ myocardial INFARC acute disease or condition Medical resulting in death) Due to (or as a consequence of) 20 Examiner artem coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury -tran that initiated events resulting in death) Last Due to (or as a consequence of): burial-/sician Physician/Medical that the death certificate be phys the b Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) ed by the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ionaestive heart failure 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should peripheral vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 K Inpatient 2 ER/Outpatient 3 DOA ည After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending the Funeral Director: Aft 2 🗌 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NP1#1063737773 Name and address of person who completed cause of death (Item 23a) (Type, Print) atherine Himore. 31. Date filed (Month, Day, Year) 5 **201**0 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 12, 2010 2:30 pM William Farrell Harrison Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Woodside Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** ocial Security Number 220-50-7912 8. Date of Birth **XX**M 2 □ F Hours 4 147 1949 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at Director Prince George's MD Greenbelt 1 Yes 2 No 10g Citizen of What Country ö 10e. Street and Number 61 B Ridge Road items 23a death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Clerical Employee 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traimastic. Elementary/Seconday (0-12) College (1-4 or 5+) Food & Drug Administr. 17. Father's Name (First, Middle, Last)
Charles Junious Harrison 18. Mother's Name (First, Middle, Maiden Surname) Lois Beaven Easterbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Oregon Ave. Apt. 310 Washington DC 20015 Jeanne Smith, si**g**ter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Chesapeake Crematory 10/15/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Sarvice Lice 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ KONARY disease or condition resulting in death) MONTIM Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine tany, leading to infractions, it any, leading to infractions cause. Enter Underlying Cause (Disease or iinjury Due to for as a consection of the as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Pregnant at time of death 5 ☐ Other (specify) Month Dav Year the should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FLUTTER, DIABETES, HTN 1 Yes 2 No 3 Probably 4 Onknown holoslato 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform certificate 1 Yes 2 No Yes 2 funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After lulatural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier The critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 0057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 209 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Andrea Vianna 2010 Harding 1:40 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3701 Ednor Road N/ABaltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Dec. 5, 1941 1 □ M 2 🛛 F Months Days 169-34-0407 Director 68 Pennsylvania Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland N/A1 1√2 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 Ednor Road U.S.A 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) vears Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Fransis Anthony Pileggi Aida Patricia Guariglia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94103 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Brian J. Barnes (son) 5th. Street #304 San Francisco, California injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Green Mount Crematory 10-15-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NG Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 [25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence filled in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOREMO MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 152010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b.perFH, G908, I0/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Day Year ARCIAR DT 5-10 P 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 40 llicott 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 215-24-948 1 ☐ M 2 🔀 F Min. (Month, Day, Year) Months Hours Country) Director 14-1930 Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Departmen Elementary/Seconday (0-12) College (1-4 or 5+) Coth grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည McKennu Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48306 - Doughter Michigan Vistaview ana 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Rebutus, MD 4 ☐ Donation 5 ☐ Other (Specify) -2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Una Noi nom 21202 Seenne 101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death HROMP Physician/ KEBRAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialed by the attending physician detached for use as the burial Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FAILURE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DUSAHACTA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed^a this certificate 2 A NO 2 1 N Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 2, No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) allan 28595 asueen

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mo

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

MITH

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc g908 10-15-10 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 | 0

32331 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 8-27-2010 3. Time of Death Physician/ 1:00р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3476 Dolfield Ave. Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 38-38-83 1 🕱 M 2 🗆 F Hours Min. 1 1 1 0 9 1 1 9 2 7 N. Carolina Director 83 Usual Residence of Decedent 10b. County 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at by Funeral Director 1 XYes 2 No N/A Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3476 Dolfield Ave. 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ XNo Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes Give Specify: Black 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry. Union Station (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mail Handler Washington D.C. 8th Grade of Health and Mental Hygitem 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Geneva White Johnnie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3476 Dolfield Ave.,Baltimore,MD 21217 Brenda M. Johnson(wife) Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 09/08/10 Baltimore, MD 21. Signature of Funeral Service Licenses ²²Josephi^{re}Hof Farbrown Jr. FUneral Home PA 21217 2140 N Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. ediate Cause (Final ase or condition Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Mesidence Hospital or Attending Phys 24 hours after death. Funeral Director: After this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 30. Name and addr pleted cause of death (Item 23a) (Type, Print) vho cor filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:25 AM Jon Leroy Johnston Medical October | 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 2 M 2 - F Days Months Hours Country) **Director** 76 Yrs 512-26-1286 30 Sep Kansas Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? the Medical Examiner must be Funeral with 23a 9602 Dunkeld Court 21236 United States items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married than "natural", or þ Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates. KOTCO White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 4 Ouality Control Manager Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwin Eugene Johnston Florence Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Judith Johnston /Wife 9206 Dunkeld Court Nottingham, MD 21236 Baltimore, OCTOBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Oct 13 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility MOLYY Cremation and Funeral Alternatives Pastures Drive Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death be detached 9 Unknown 9 Unknown JON JOHNSTON signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 2 X No 1 \sum Yes 2 No Division of Vital or Attending Physician: director 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of : After t 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 🗌 Yes 24 hours after death 2 🗌 No 2 Accident
3 Suicide
4 Homicide the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and the of 29d. Date signed (Month. Dav. Year) 2010 0

DHMH 17 Rev 7/2009

State

Registrar

JACKIE

31. Date filed (Month, Day, Year)

JONES

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TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32333 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTO DO 6:45 PM KREYMER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital 0f 9 Baltimore N/A Social Security Number If Under 1 Year If Under 24 H Birthplace (State or Foreign Country)
 RUSSIA 8. Date of Birth **Funeral** 1 M 2 F 0572371927 Director 220-33-1803 83 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traun atic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 FORDS LANE 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INTERPRETER AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should re file Department of Health and Mental I Important: If item 27 is narked o **PSHITYKEVICH** NATHAN SONYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 FORDS LANE, BALTIMORE, MATVEY KREYMER/HUSBAND MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place MX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 10/11/2010 REISTERSTOWN, MD Signature of Funeral Servici. Livery ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final intracranial hemorrhage Onset and Death Physician/ disease or condition resulting in death) Medical ikely secondary to chronic anticoagulation therapy for Due to for as a consequency of: Atmial Fibrillation Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for Pregnant at time of death Month Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 2 No 3 Probably 4 Unknown 24a. Was an 246. Were autopsy findings available prior to completion of cause of death? 1 Yes 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? Natural injury 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singi Hospital of Baltimore

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a,25 per me,g908,10/15/2010dhb
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 2Day 2010 ear Georgia Lee Keeling 4:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Dec. 8, 1937 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2X F Hours North Carolina Director 234-56-8350 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Harford Maryland Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3407 Cedar Church Road 21034 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Year or Dates White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Machine Operator Clothing Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry William Daugherty Carrie Bell Mahaffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L..Sexton/Daughter-in-law 2213 Gregory Drive, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 10-6-10 Darlington, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Hematoma (Spontaneous) Suboliva Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of TION APPROVED BY MEDICAL EXAMINER After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) _____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an I or Attending Physician: The law after death.

Director: After this certificate has I in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 Ninpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Curtifying Nurse Practioner To the best of my knowledge, draft pround of the time, date and place, and due to the 29b. Signature and title of certifier 10/2/10 Uchendry M D66136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 nnenna ulhenau UPPER CHESAPEAKE RR BELAIR 31. Date filed (Month, Day, Year) OCT 152010 Registrar

04:30 AM

tax

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 10 Month Physician/ 2010 05:49 J. Lowery Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville 8641 Richmond Avenue 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Country) 0372971930 MD Director 215-26-6464 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Merical Hygiene. The triems 23a or 28a-f sho ritem 27 is merked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 X No Parkville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe U.S.A. 21236 8641 Richmond Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Never Married 2 Married ģ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Shingledecker Edna Allie Hines William permit. Page 1 and 2 should by Department of Health and Nen Important, If item 27 is mark, any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7850 Rossville Blvd. Suite 200 Baltimore, MD 21236 Richard Hammond, Grandson 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
 10/15/2010 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. JBlair Suprael 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition MESOTHELIOMA Physician/ Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 4 W Unknown 3 Probably 1 Yes 2 No Division of Vital Records, MELLITUS 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? completed filled in by the funeral director, page 2 autopsy performed' 2 🗌 No 1 🔲 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🔲 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 6830 HUSPINLDV# 0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

15 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2010 <u>Olive Jane Lozanski</u> 80 8:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Air Health and Rehab. Center If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2 🔀 F Months Days Maryland Hours Director 219-10-8237 Usual Residence of Decedent or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6609 Mt. Vista Road 21087 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ☒ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaking Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Robinson Bertha Bannister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John W. Lozanski</u> 6609 Mt. Vista Road - Kingsville, Maryland 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Air Memorial Gdns: 10/12/2010 | Bel Air, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 1750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the disease, and one tenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition non/ Medical resulting in death) Due to (or as a con equence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a P.O. si nificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 🗌 Yes 🛮 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>010</u> Physician/ Month October Dolores Laurini Lewis 1 РМ 2:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Buckinghams Choice Adamstown Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day,) Months Days Hours Min. New York **Director** 97 073-09-6545 March 1913 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Frederick Adamstown Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral U.S.A. 3200 Baker Circle 21710 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedor. Armed Forces? 1 ☐ Yes 2 🔯 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Film Manufacturing Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ဂ Eleanora Perotta Vincent Laurini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 Taney Rd., Baltimore, MD 21209 Linda Saffer (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Riverside Cemetery Rochester, NY 10-08-2010 onation 5 🗌 Other (Specify) 21. Sign 22. Name and Address of Facility neral Service Lic Thomas Funeral Chapel 4545 Lake Avenue, Rochester 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Atherosclerotic Vascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence or). Examin **To the Hospital or Attending Physician:** The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No ☐ Pregnant at time of death ☐ Unknown Month g Unknown Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate 2 💢 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 ANO Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 \square Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident within 24 hours after death

To the Funeral Director: A Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Oct. 4, 2010 D0058726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000-D Ventrie Ct., Myersville, MD 21771 Yvette M.L. Warren, M.D 31. Date filed (Month, Day, Year, Registrar's Signature State 1 5 2010 Registrar

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	Physicia Medic	al		Carl Bern	nard	Larsen		2. Date of Deat Octobe		3. Time of Death 9:10 au		
To the second	Examin		4a. Facility Name (if not institution, give stre Hospice of the C		<u> </u>	4b. City, Town, or Harwo	Location of Death		4c. County of Death Anne Arundel			
	Funeral Director		5. Social Security Number 6. Sex 1 0 3 - 1 4 - 6 5 8 2 1 🕱	7. Age (<i>In yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar. 3				
	aryland a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County Anne Ar		ity, Town or Lo	cation Anr	napolis			10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	with the M 23a or 28 ust be noti	Funeral Dir	10e. Street and Number 680 Americana	Drive		10f. Zip Code 21 4	103	1	l 0g. Citizen of What			
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 Xes 2 No US If Yes, Give 1941–1 Year or Dates.		Was Decedent of His f Yes, specify Cubar 1 Yes 2 XNo	spanic Origin? (Spe i, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White		
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Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 2 once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		cemetery crer	osition (Name of matory or other place ourney Cro	a) i		20c. Location - City Woodbine			
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	Sorota Marsh		Name and Address Marylan PO Box	of Facility d Crema 1413, B	tion So	ervices re, MD 2	1203		
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09	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last	Due to (or as a consec					10 Majo			
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of g ☐ Unknown	taldeath 3 L	Ectopic pregnancy	у		23d. Date of Month	delivery Day Year		
s, P.O.	iires that the signed by Id be deta	d by PI	Part II. Other significant conditions contr	buting to death but not re	esulting in the u	underlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown		
Record	The law requate has beer bage 2 shou	Completed by						24a. Was ai autops perfori 1 \(\sum \) Yes	sv prior t	autopsy findings available to completion of cause of ? Yes 2 \sum No		
24a. Was authors and the part of the part										ecify) facility		
ivision	I or Attendi after death Director: A I in by the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str fy)	4 1000	Yes 2 □ No	28f. Location (St. City or Town	reet and Number or i	Rural Route Number,		
	e Hospita 124 hours e Funeral leted fillec	Medical	(Check / Medical Examiner	an: To the best of my know On the basis of examinati ractioner: To the best of r	on and/or inves	tigation, in my opinio	n, death occurred at	t the time, date an	d place, and due to the	ne cause(s) and manner stated.		
	withir comp	2	29b. Signature and title of certifier	13 40 354 011	, injuriedge,	29c. License	_		9d. Date signed (Mo			
	44		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type, F	Print) QArku	AV SUN	x 210	Ann	ols MO 2140		
Ī	Stat Registra		31. Date filed (Month, Day, Year) OCT 1 5 2010	32. Registrar's Sign	parti	/		-				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medic Examin			not institution, give	e street and number)			4b. City, Town, or	Location of Death		4c. County of Death		
4			ry at Ho									omery
Funeral Director		5. Social Security No. 104–36–3		Sex 7. Ag	e (In yrs. last 65	t birthda Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 5,	th ay, Ye <i>ar)</i> 1 0.4	9. Birt	hplace (State or Foreign Intry) York
		Usual Residence of	Decedent						oan 5,	174	<u> </u>	
ıryland a-f sho	ctor	10a. State	10b. County	a	10c. City, 1	lown or						10d. Inside City Limits 1 ☐ Yes 2 😾 No
the Ma or 28a	Dire	Maryland 10e. Street and Nun		George's			Laurel 10f. Zip Code			10g. C	g. Citizen of What Country?	
s 23a	Funeral Director	13801 Be	lle Chas	se Blvd #1	12	20707 United Sta						es
r item		11. Marital Status	ied 2 Married	12. Was Decedent Armed Forces?		.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - Amei Black, White	
s after ral", o Exam	ed by	3 XWidowed		1 Yes 2 X If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🔀 No Specify:					Specify: Wh:	ite
2 hour "natu	Completed	(Spe	15. Decedent's E				cedent's Usual Occup ve kind of work done o		kina	16b. i	Kind of Business	industry
ithin 7 ene. • than	Com	Elementary/Seco	onday (0-12)	College (1-4 or 5	5+)		lic School	Toachor		D	G Count	y Schools
illed w Il Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)	<u> </u>		Puo	TIC SCHOOL	18. Mother's Nar				LY BEIROIS
ld be f Menta arked atic e	P.	Donald	George	Wilkie				Jeanne	Eunio	ce	Mundt	
shou h and 7 is m traum		19a. Informant's Na					ailing Address (Street					
and 2 Healt tem 2		JUSTIN B 20a. Method of Disp	bruce Len	ey/son			Sherriero sposition (Name of	Marior 1	Date		ocation - City or	ng, MD 20904 Town. State
Page 1			Cremation 3 5 Other (Spec	Removal from State	cen	netery, c	rematory or other place					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur										784 e, MD 21029
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		shock, or hear Immediate Cause (rt failure. List only	one cause on each line	е.	19	enter the mode of dyin				. 20	Approximate Interval Between Onset and Death
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sit sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying	Due to (or as	a consequer	nce of):						
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irtificat ling ph e as th	Physician/Medic	IF FEMALE:		23c. If yes, outcome	of programs							
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the deby the ached	hysi	9 Unknown	- 110	g 🗌 Unknown								
ss that igned be det		Part II. Other signif	1 3000	_	out not result	ing in th	e underlying cause giv	en in Part I.				the cause of death?
require	Completed by	7,000	• •	MELLITE								obably 4 Unknown
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an: Th tificate tor, pa	Be Co	25. Was case referre	ed to predical				26. PI	ace of Death (Che	1 🗆 Yes	P	lo 1 ☐ Yes	2; No
hysici his cer I direc	To E	examiner?		Hospital: 1 Inpati			tient 3 DOA Dthe	er: 4 Nursing H	ome 5 🗆 Resi	dence	6 Other (Speci	fy)
Jing Pl	ate:	27. Manner of Death 1 Natural	5 Pending	28a. Date of inju (Month, Da		Bb. Time injur	work	?	28d. Describe I	how inju	ry occurred	
Attence r death	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigatio 6 Could not be determined	28e. Place of Inju		e, farm,	M 1 Ll street, factory, office	Yes 2 No	28f. Location (Street ar	nd Number or Rur	al Route Number,
tal or rs afte al Dire		4 Hornicide	determined	building, et	c. (Specify)				City or Tov	vn, State	e)	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	Medical	(Check 2		iner: On the basis of e	xamination a	nd/or inv		on, death occurred	at the time, date a	and place	e, and due to the o	ause(s) and manner stated
o the vithin 2 the comple	M	only one) 3 29b. Signature and		se Practioner: To the	best of my k	nowledg	e, death occurred at the		ace, and due to th		(s) and manner as ate signed (Month	
- > - 0) Ja	A 110111	Laso	ann	ns	1 12	8555		12	0/12/1	Ó
NON		30. Name and addre	ess of person who	completed cause of d			Print)		~ A		1 1	6) =
8		J/JSNE 31. Date filed (Month)	Day, Year)	1-KI-AT	VI M. ar's Signatur		1835 Sm	11H th	EIB	AL	TO MA	21209
Stat Registra	e ir	31. Date filed (Month	UCT 152	010 Sense	W Z	1.	backel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) AM ID Town, or Location of Death 4c. County of Death 4b. City. last birthday Min. Months Days Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County 1 ☐Yes 2 ☐ No 10g. Citizen of What Country? Street and Number 12. Was Decedent Ever Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, in U.S. 11. Marital Status Black, White, 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ost of working Elementary/Secondary (0-12) 18. Mother's Name (First) Middle, Maiden Surnam 17. Father's Name (First, Middle, Last, 19b. Mailing Address 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition sessis

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

10a. State

10e

Funeral Director

Completed by

Be 2

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, it o No. item Examine must be notified at another.

Physician/Medical Examiner Be Completed by Certification: To

resulting in death)	Due to (or as a consequence of):			weeks
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Our Marie Due to (or as a consequence of): d			years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of do Month	alivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.		o use contribute 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 Unknown
Hypertension		24a. Was an autopsy performed? 1 □ Yes 2 ☑ 1	prior to death?	autopsy findings available completion of cause of s 2 \sumbed No
25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residence	6 ☐Other (Sp	ecify)
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or F ate)	Rural Route Number,
29a. Certifier Certifying Phy	ysician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cause	(s) and manner	as stated.

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin AKTHUR 31. Date filed (Month, Day, Signature State 1 5 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 1:57pm 2010 October 13. Physician/ Medical 4b. City, Town, or Location of Death Belair 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number)
Belair Health & Rehabilitation Center Examiner 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 98 Yrs. If Under 1 Year Social Security Number August 4, 1912 **Funeral** Months Days Hours ^cîtaîv 1 M 2 F 215-12-3736 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Harford Belair 1 Yes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Italy 23a Funeral 21014 535 Hanna Road must 14. Race - American Indian, or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. White traumatic event, the Medical Examiner 1 Never Married 2 Married 1 Yes 2 No ģ 1 Yes 2 No Specify: Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturer Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Agostinelli Joseph Biancucci 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 535 Hanna Road Balair Maryland 21014 Joseph Mingioni/Son 1 and 2 s f Health item 27 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Loudon Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page 1
Department of
Important: If it
any injury or o Baltimore Marland 10/18/10 22 Name and Address of Facility Leonard J. Ruck, 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) ng physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical death certificate be Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery use 23b, Was decedent pregnant Day Month in the past 12 months? for been signed by the should be detached 9 Unknown the Hospital or Attending Physician: The law requires that the P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular disease 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performe 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25 Was case referred to medical Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27, Manner of Death Certificate: work?
1 Yes 2 No injury 1 Natural 5 Pending М n 24 hours after death.

Re Funeral Director: A pleted filled in by the fu Accident Investigation 2 Acciden 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical within 2. 29b. Signature and title of certified October 14, 2010 P0063981 Mp. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Lee, mp 669 Revolution St

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1 5 2010

32. Registrar's Signature

Harre de Grace, MD 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32342 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ G. Gladys Montgomery October 11, 2010 5:00 p. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Citizens Nursing Home Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours May 12 ay, Year 15 Mary Tand 578-26-2722 95 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick 1 X Yes 2 ☐ No Thurmont 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 124 Redhaven Ct. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Tes 2X No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Webster Plummer Gover Alice Maude Ireland permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic « 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Montgomery (son) 124 Redhaven Ct., Thurmont, MD Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Cedar Hill Cemetery 10/14/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between lhrombos() Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cayus ritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: Natural 28d. Describe how injury occurred 5 Pending Accident Investigation within 24 hours after death To the Funeral Director, 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Qertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ar certifier 29d. Date signed (Month, Day, Year) 00062223 10

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month)

FLEIBREK MY 21702

person who completed cause of death (Item 23a) (Type, Print)

196

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maria G. Murray October 13, 2010 6:32 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Air ear If Under 24 Hrs. Upper Chesapeake Medical Center 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🏻 F Months Davs Hours Min. (Month, Day, Year) **Director** 88 219-18-4613 Nov 1921 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director MD Harford 10/13/10 White Hall 1 Yes 2 D No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4827 Norrisville Road 21161 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or ð 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Elkanah Greenwell Rebecca Marie Fenwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Robert Murray 1167 Linden Avenue; Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) orraine Park Cemetery 10/18/2010 Woodlawn, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville, MD 21228 21, Signature of Ameral Service Lice 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Massive Haite Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical W. f CLU 11 LW () A COO 45 O Division of Wtal Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Day 9 Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 🗌 No 2 X No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Tes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D661 10/13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UCHENDY 500 UPPERCHESAFEAKE BELAIR MD 21014 NNENNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			For State Registrar	State of M	arylan	•	artment of I tificate of I		Mental Hy	giene Reg. No.2 (010	32344
	Physicia Medic		Decedent's Name (First, Middle, BERNICE	Last)	MILI	LER			2. Date of De Month		Year 2010	3. Time of Death
	Examin		4a. Facility Name (if not institution, Sinai Hospital		ore			r Location of Deat	h	4c. Cour	nty of Death	1
	Funeral Director					ast birthday) Yrs.		If Under 24 Hrs Hours Min.	8. Date of Bir	th	g. Birth	nplace (State or Foreign ntry) DC
	yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	·	10c. Cit	y, Town or Loc	cation		· <u>- · · · - · · · · · · · · · · · · · ·</u>			10d. Inside City Limits
	the Mar or 28a- se notifie	I Director	MD BALT 10e. Street and Number	IMORE	BA	ALTIMOF	RE 10f. Zip Code			10g. Citizen o	of What Cou	1 Yes 2 No
	h with ns 23a nust b	Funeral	19 FRIENDSWOOD				21209			USA		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Narital Status Never Married 2 Marri Widowed 4 □ Divorced	ed 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	Vas Decedent of History Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - Ameri lack, White, i ^{fy:} WH	
15-0	2 hour	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		(Give k	lent's Usual Occup	during most of wo	rking	16b. Kind of	Business In	ndustry
2121	vithin 7 jiene. er than the M	Elementary/Seconday (0-12) College (1-4 or 5+) ife. DO NOT use retired) BOOKKEEPER STATE								TE OF	MARYLAND	
Baltimore, Maryland 21215-0036	So set to be								,	HRIBER		
Mar	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State PHILLIP MILLER/HUSBAND 19 FRIENDSWOOD COURT, UNIT B, BALTIME											
re,	1 and of Heal item 2		20a. Method of Disposition			lace of Dispos	sition (Name of	1	Date	20c. Location		
timo	t. Page tment or tant: If		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	pecify)			CHIZUK A		14/2010	BALT	IMORE	, MD
Bai	22. Name and Address of Facility SOL LEVINSON & BROWN ROAD, PIKESVILLI											
	nysician	î s	23a. Part F. Enter the disease, or of the control o	a.	e.		r the mode of dyir	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death Clay
دس. و ^{ري}	Examiner		,	Due to (or as	a consequ	uence of):						,
	sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ience of):						
	executed ian and inal-transit		that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):						
200	cate be physic the bu	edica		d								
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	су			Date of deliverself	very Day Year
ls, P.O	uires that th n signed by uid be deta	ed by Pł	Part II. Other significant condition Corovary aftery		ut not res	ulting in the ur	nderlying cause gi	ven in Part I.				the cause of death?
Division of Vital Records, P.O.	l or Attending Physician: The law require atter death. Director: After this certificate has been sit in by the funeral director, page 2 should I.	Complet	Anoxic brain in	rucy					24a. Was autoj perfo 1 🏻 Yes	osy ormed?		opsy findings available ompletion of cause of
ital	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	_		Oth	ace of Death (Che				
of V	ig Physter this	te: To	27. Manner of Death	28a. Date of inju	ry	ER/Outpatien 28b. Time of injury	t 3 □ DOA 28c. Injur	4 ∐ Nursing F y at	lome 5 Resident			·y)
ion	ttendin death. tor: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investige 3 Suicide 6 Could n	ation of he				Yes 2 No				
Divis	ital or A	al Cer	4 Homicide determin				et, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
	the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination	and/or investi	gation, in my opinion in the control occurred at the c	on, death occurred e time, date and pl	at the time, date a	ind place, and o	lue to the ca	ause(s) and manner stated.
	5 v vi		29b. Signature and title of certifier Ceucha Yshin					e number S - 00 0		29d. Date sign		
3			30. Name and address of person w Cecilia Yshii - To	ho completed cause of d amashiro M	eath (Item	23a) (Type, Pi	rint) ospitalo-	f Baltim	ore			
	Stat Registra	C	31. Date filed (Month, Day, Year) OCT 15 2010	32. Registra								
DHI	AH 17 Rev 7/20		001 40 2010	Mary Mary	1							

State of Maryland begarine of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death MORGAN Month Year Physician/ CLAIRE Day LORNA 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD COUNTY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/16/1945 9. Birthplace (State or Foreign **Funeral** Days 65 Yrs. Director 100-44-4615 Jamaica Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f shor Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No FLBroward <u>Sunrise</u> 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3720 NW 88th Ave. Apt#333 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates Specify: 3 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired College (1-4 or 5+) Elementary/Seconday (0-12) <u>Disaster Specialists</u> American Red Cross Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ments
Important: If item 27 is marked
any injury or any Wilford Morgan Hazeldean Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Stoessel / Sister 5019-6 Green Mountain Circle Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Dovecot, Memorial Park 1 Burial 2 K Cremation 3 K Removal from State 10-30-1010 Kingston, Jamaica 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, PA 9013 Annapolis Road Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of Examiner METASTATIC OVARIAN Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown rate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 2 1 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2V No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical † Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD Mylwily D0064760 9,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE # 310 MYTHILY VANCHA 10710 CHARTER DRIVE COLUMBIA, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Losephine acewicz October 2010 6:43a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Months 059-26-1132 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Eldersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1317 Placid Drive 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗓 No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rapp Anna Mayrhofer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Nacewicz (spouse) 1317 Placid Dr., Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State All County Cremation 10-13-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Haig Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final neumonia Physician/ disease or condition Medical resulting in death) Accident **Examiner** evenvo vasalor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and I-transit Exam The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 TNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

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152010

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mary O' Neill 10:45PM 2010 october 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore</u> Randallstown Seasons Hospice 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, 1 □ M 2 😾 F Days Hours Min Country) 93 Feb. 212-10-4522 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Willington Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 ☐ Never Married 2 🔀 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u> Housewife</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James McManus Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0'Nei11 37 Willington Court, Owings Mills, MD 21117 Arthur Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/10 Carroll Cremations Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CardioThrombotic Event Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cardiovascular Disease Atherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of)

Pry_ician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

or 28a-f shov

items 23a or 28a-f sho her must be notified at

Examiner

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permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical > 24 hours after death.
Funeral Director: After thieted filled in by the funeral

or Attending Physician; The law requires that the death certificate be executed

To the Hospital within 24 hou

To the Fune

completed fi

Division of Vital Records, P.O. Box 68760

	d		
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
5. Was case referred to medical	26. Place of Death (Che	eck only one)	
examiner?	Hospital: Other:	5 D B. dalana	In-patient hospice

ed E			1 Yes 2 No 3 Probably 4 Unknown								
comple			24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No								
Ф	25. Was case referred to medical	26. Place of Death	(Check only one)								
0	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
ricate:	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		28d. Describe how injury occurred								
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ica i		ician: To the best of my knowledge, death occured at the time, date and pla									

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

ns Rajapahrem 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 5miTh Av. 5-203, Baltimore, MD. 2/209

N. S. Rajapakse, M.D.

D0057 465

10/14/10

31. Date filed (Month, Day, Year **0CT 15 2010** State

32. Registrar's Signatur parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11 15-10 vt. State of Maryland / Department of Health and Mental Hygiene 32348 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29^{Day} Physician/ 0 Month MARY OVERBY 2010 5:00A M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1520 W. North Ave. #611 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F N. Carolina 213-26-0416 Yrs. Director 82 MARCH 2, 1928 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral 1520 W. North Ave. #611 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race ~ American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Grade house cleaning domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file rand Mental H ည Frank Locklear Serenia Overby Jep. Namit. Page 1 and 2 sho.
Department of Health and Important: If Item 27 any injury or c... 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Parker(nephew) 1015 Lavon Dr., Richmond, VA 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ANS EPEMBESTY F 10/01/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility

505EPH H. GROLD N JR. FUNERAL HOME
2140 N. FULTONAVE, BALTIMORE, MD 2121 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ArTerios clerates Cardionas autor diseos Physician/ disease or condition resulting in death) Medical **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Usleo porosis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Degeneralist Joint disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Hospital or Attending Physician: The completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (specify) (10 114) 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 I franklin faddeson. mo D20099 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Addison Franklin 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1917 AM Physician /Medical Rosetta october 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday **Funeral** Months 1 M 2 K GA 9-3-1936 **Director** 259-54-7882 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show notified at 10b. County 1 X Yes 2 ☐ No Director Baltimore MD na 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA ed other than "natural", or Items 23a or event, the Medical Examiner must be in 21213 Chapel Street 1611 N. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes If Yes, Give 2 X No 1 Never Married Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Meridian N/H Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Louise Porter Walter Johnson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21223 1818 W. Lexington Street Aloha Peters-daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-18-2010 Balto, MD Greenmount 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Entertine disease, or complications that Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Ventricular tibrillation **Physician** /Medical Due to (or as a consequence of) **Examiner** schemic heart di if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IE EEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 | Fetal death Pregnant at time of death 3 Ectopic pregnancy ed by the attended for u Month Year in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?

1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Injury After 1 Natural thin 24 hours after death.

the Funeral Director: After ompletely filled in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the comple 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 071333 October 11, 2010

Registrar

State

32. Registr Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melinda Morton

31. Date filed (Month, Day, Year)

32. Registra s ignature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / I - State Amend Item 25 per me,g908,10/	Department of Health and N 15/2010dhb Certificate of Death	/lental Hyg R	iene _{eg. No.} 2010 32350
	Physicia		1. Decedent's Name (First, Middle, Last) Thomas Leo Proctor, S	Sr.	2. Date of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number) 2810 Tucker Road	4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince George's
, mar 8	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	Birthplace /State or Foreign
	Director		5/9-20-5551 84 Usual Residence of Decedent	Yrs.	Jan. 5, 1	926 Maryland
	aryland a-f shor fied at	Director	10a. State 10b. County 10c. City, Town Maryland Prince George's Fort Was			10d. Inside City Limits 1 □ Yes 2 🛣 No
	a or 28 be noti	al Dire	Maryland Prince George's Fort Was	10f. Zip Code		0g. Citizen of What Country?
	eath with	Funeral	2810 Tucker Rd. 11. Marital Status 12. Was Decedent Ever in U.S.	20744 13. Was Decedent of Hispanic Origin? (Spe		J.S.A
036	rs after de ıral", or it. Examine	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☑ Yes 2 ☐ No WIII 1 ☐ Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2XX No Specify:	Rican, etc.)	Black, White, etc. Specify Native American
Maryland 21215-0036	ified within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business Industry Government AAFB
1d 21	filed with al Hygier d other t event, th	a	12 Head 17. Father's Name (First, Middle, Last)	ating Engineer 18. Mother's Nam	e (First, Middle, M	
ylar	Q E 3 0	2	Thomas Harris Proctor	Gracie Ann		
, Ma	shr is rau			. Mailing Address (Street and Number or Rura 45 Lowell Rd. Pomfret, MD		City or Town, State, Zip Code)
nore	Page 1 and ment of Heal ant: If item ury or other		20a. Method of Disposition 1XX Burial 2 \square Cremation 3 \square Removal from State 20b. Place of cemeters	ry, crematory or other place)	1 0010	20c. Location - City or Town, State
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		21. Signature of Foreral Service Licensee	22. Name and Address of Facility Lee	Funeral H	
_	<u></u>		23a. Par/1. Enter the chease, or complications that caused the death. Do not	6633 Old Alexandria Fer		st, Approximate
	Physician/	6. 5	shock, or heart failure. List only one cause on each re. Immediate Cause (Final disease or condition	hermore Di	reas	Interval Between Onset and Death
and the second	Medical Examiner		resulting in death) Due to (or as an insequence of	ரி: -		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	m 2 9 7) a	22
	icate be executed g physician and is the burial-transit	l Exa	that initiated events resulting in death) Last Due to (or as a consequence or	if):	M	ED BY MEDICAL EXAMINER
9	certificate be inding physic use as the bu	ledical	d arter	CER ¹	IFICATION APPROV	Eng
ŏ n	death ne atte ed for	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
л. О	s that the gned by se detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		acco use contribute to the cause of death?
ords,	requires been siç should b	Completed by	Company of standing	and the man	1 Tye	s 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
Xec Xec	The law ate has page 2:	Somp	subdural hygrama	, cherry	autopsy perform	orior to completion of cause of death?
Ita	sician: certific	Be	25. Was case referred to medical examiner? 1 A Yes 2 No 1 Inpatient 2 FR/Out	26. Place of Death (Check		
n of v	iding Phy th. : After this funeral d	cate: To	27. Manner of Death 28a. Date of injury 28b. Ti		ime 5 🗷 Resider 28d. Describe how	nce 6 Other (Specify) v injury occurred
Division of Vital Records,	al or Atter s after des I Director d in by the	Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not only one) 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practioner: To the best of my knowledge, do not only one)	r investigation, in my opinion, death occurred at	the time, date and	place, and due to the cause(s) and manner stated.
	To t with To t		29b. Signature and title of certifler	29c. License number D 000 8370		0d. Date signed (Month, Day, Year)
	1401		30. Name and address of person who completed cause of death (Item 23a) (The Paul Pritchett, M.D. 118 LaGrange Ave,		1	
	Stat Registra		31. Date filed (Month, Day, Year) 0CT 15 2010 32 Registrar's Signature	barres		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	ate of Maryland	-	rtment of H			711	10	32351
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer		reali i	2. Date of Deat	eg. No. 😘 💟		3. Time of Death
F	Physicia Medic		Joseph Leo Poule	ette				Month October	Day	Year 2010	3:07am M
	Examin		4a. Facility Name (if not institution, give street a	nd number)		4b. City, Town, or	Location of Death		4c. County		
			BaltWash. Medical (Center		Glen Bu	rnie		Anne	Arun	del
	Funeral Director		5. Social Security Number 6. Sex 1 🕅 M 2	F 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, July 21		9. Birthp Count	lace (State or Foreign ry) MA
	MC .		Usual Residence of Decedent								
ylanc	fsho	ctor	10a. State 10b. County		Town or Loc					10	0d. Inside City Limits
Mar	28a notifi	Director	MD Anne Arunde	21 G	len B	urnie					1 ☐ Yes 2 🔀 No
th th	3a ol	a	10e. Street and Number						10g. Citizen of W		
th w	D o C C I Nover Married 243 Married 1 1 X Ves 2 U No								- ī		
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2-UUSO 2 hours after									Wh	ite	
-hour	Specify: Specify:									siness Ind	lustry
(Give Airid of Work doine during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)											
N Plant	tygier ther t nt, th	BeC	12			Barber				ber	Shop
Viand d be filed	r Health and Mental Hyg item 27 is marked othe other traumatic event,	10 B	17. Father's Name (First, Middle, Last) Joseph A. Poulette					ne <i>(First, Middle, N</i> ene Touss	,)	
and b	d Me mark matic		19a. Informant's Name/Relationship (Type, Prin	*1	10h M-10-	g Address (Street a				ata Zin C	anda)
2 sho	th an 27 is trau		Eileen Poulette	·		E. Furnac			-		-
and and	r Hea item other		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of	1		20c. Location -		
Dalumore, permit. Page 1 and	nt: If		1 ☐ Burial 2 X Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al IIOIII State		atory or other place remation	· •	1-2010	Hampste	ad.	MD
il i	Departm Importa any inju once,		21. Signature of Funeral Service Licensee	0		Name and Addres	•	ELINE FU			1115
å ë å	8 E 8		1 2HXVSE	<u></u>	11	824 Reist	terstown				D 21136
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	s that caused the death. I	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
4	sician/		Immediate Cause (Final disease or condition	CARDI	AC	- 1713	LRES	T			Onset and Death
	Medical aminer	ı	resulting in death)	Due to (or as a consequen	ice of):	Aure.	0.4	DICK NO	· C		1
		je je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ice off:	14615	LY	DISEAS) [_	-	
peq	nsit] <u>Ē</u>	cause. Enter Underlying Cause (Disease or iinjury	TYPE -1	1 5	DUANFI	GS M	ELLIT	UC		
execu	n anc ial-tra	Ä	that initiated events c resulting in death) Last	Due to (or a a consequen	ice of):	7 10 11 1	17		-		
te be	ohysician and the burial-transit	dical Examiner	d								
oo / o	as th	100	IF FEMALE:		- 47-2					- 1	
A o	tendii or use	ian/	23b. Was decedent pregnant 23c. If y	es, outcome of pregnancy Live Birth 2 - Fetal d	eath 3		y			e of delive	
e death	been signed by the attending p should be detached for use as i	Physician/M	1 Ves 2 No 4	☐ Pregnant at time of dea ☐ Unknown	ith 5∟	Other (specify)			Mor	IUI	Day Year
at th	ed by detac		Part II. Other significant conditions contributi	ng to death but not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contri	bute to the	e cause of death?
U, T	sign Id be	d by						1 □ Ye	es 2 🗆 No	3 🗌 Prob	ably 4 Unknown
ecorus, e law requires	shou	Completed						24a. Was a		/ere autop	sy findings available
he lay	te has age 2	mo						autops perform	med? d	rior to con eath? Yes	npletion of cause of
an: I	rtifica tor, p	Be C	25. Was case referred to medical			26. Pla	ace of Death (Che		224110	103	
VILCII nysician:	direc	10	examiner? 1 Yes 2 No Hospita	1 Inpatient 2 KEF	R/Outpatien	3 DOA Othe	r: 4 Nursing H	łome 5 🗌 Reside	ence 6 🗆 Othe	r (Specify)	
o ing Pr	fter thuneral		27. Manner of Death 1 Natural 5 □ Pending 28a	. Date of injury 28 (Month, Day, Year)	Bb. Time of injury	28c. Injury work	?	28d. Describe ho	w injury occurre	d	
VISION or Attendin	tor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injury - At home	farm stro		Yes 2 No	28f. Location (St	mat and Numba	e or Duml	Pauta Number
al or A	Direct Direct Direct		4 Homicide determined	building, etc. (Specify)	s, raim, suc	et, lactory, office		City or Town		or nurar	noute Number,
DIVISION OF VILAI RECORDS, F.O. BOX 00/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours after death	winning the funds area to again. To the Fundral Director. After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: T (Check 2 Medical Examiner: On only one) 3 Certifying Nurse Pract	the basis of examination ar	nd/or investi	gation, in my opinio	n, death occurred	at the time, date an	d place, and due	to the cau	se(s) and manner stated.
To th	70 th		29b. Signature and title of contifier			29c. License	number		9d. Date signed	(Month, D	Pay, Year)
			HUSam	7~~		MD3	7250		10/8/	201	0
VI			30. Name and address of person who complete	ed cause of death (Item 23	Ba) (Type, Pi	rint)	Const	WC / 16	- LI D (1)	2.116	40
1 1	Stat	0	HSHWAMI K-ISASS 31. Date filed (Month, Day, Year)	20 Designaturale Classes un		LDRIVE	- 301115	100 GLE	-17 15VX	HIL	FID
7.4	Stat Registra		OCT 15 2010 Gener	32. Registrar's Signature	ted						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3,2010 Physician/ 11:30A October 0 Theresa Anna Payton Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Perry Hall 3704 Mill Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Months Maryland Director January 217-24-0800 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location **Funeral Director** 1 Yes 2 X No Abingdon Harford Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21128 4354 Chapel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (154 or 5+) Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona A. Strayland ပ Charles E. Kline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Abingdon, Md, 21009 3704 Mill Road Danny Payton 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-18-2010 Middle River, Md. Holly Hills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service License ^{2. Name and Address of Facility} Schimunek Funeral Home 9705 Belair Road Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): BAT WRE **Examiner** HEART CONGEST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or se a consequence of, or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ned by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 -25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one 29b. Signature and title of certifier Show MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 PHILADERHIA RD, Surte 200 DENNIS It. ODIE 31, Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygieno

			For State Registrar	State of Mary		tificate of L			g. No. 2010	32353			
	Physicia		1. Decedent's Name (First, Middle, Last) LILLIAN RUTH F					2. Date of Death	93, 20°70	3. Time of Death 11:55 Р.м			
	Medic Examir		4a. Facility Name (if not institution, give s				Location of Death		4c. County of Death				
	Funeral Director		213-16-6722	7. Age (In	yrs. last birthday) 89 Yrs.		VEN VILLA If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 7/31/19	BALTIMOR Gear) Gear) Gear) MAR	nplace (State or Foreign ntry) YLAND			
	yland f show ad at	tor	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Loc	cation				10d. Inside City Limits			
	th the Mar 3a or 28a- t be notifie	al Director	MD BALTIMOF 10e. Street and Number 8119 GLEN GARY ROA		LOCH RAVE	ON VILLAGI		10	g. Citizen of What Cou USA	1 🗆 Yes 2 🔀 No			
920	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral		12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am Black, Wh 1 □ Yes 2 ☒ No Specify: Specify: WH				etc.			
Maryland 21215-0036	within 72 hour giene. er than "natu er the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Seconday (0-12) 12TH GRADE		(Give I	ent's Usual Occupa kind of work done of O NOT use retired)		king	6b. Kind of Business In				
yland 2	ild be filed v Mental Hyg narked othe natic event,	To Be	17. Father's Name (First, Middle, Last) GEORGE ANDREW ALE	RECHT				ne (First, Middle, Ma					
Man	2 shou th and 7 is m traum		19a. Informant's Name/Relationship (Typ		1				ity or Town, State, Zip				
Baltimore,	age 1 and 2 ent of Healti nt: If item 2 y or other i		DARRELL COVELL/NEP 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispos cemetery, crem	natory or other place	e)	Date 2	VILLE, MD Oc. Location - City or T BALTIMORE				
Balti	permit. Page 1.8 Department of P Important: If ite any injury or of	K 93	Signature of Funeral Service Lensee MO/1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286										
7	Medical Examiner	Examiner	23a/Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (1 as a co	nseq rence of)	r the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death			
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2.4 No g ☐ Unknown Part II. Other significant conditions con	Bc. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3 Lene of death 5 Lene	Other (specify)		23e. Did toba	23d. Date of delive Month accounts contribute to the contribute to	Day Year			
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of V	ng Phys ter this neral dii	te: To	1 Yes 2 No	1 ☐ Inpatient 28a. Date of injury (Month, Day, Ye	2 ER/Outpatien 28b. Time of injury	28c. Injury	4 ∐ Nursing H	ome 5 Residence 28d. Describe how	ce 6 C Other (Specifing Injury occurred	/)			
ivision	or Attendir after death. Director: Af in by the fu	Certificate:	1	28e. Place of Injury - building, etc. (S)	At home, farm, stre	M 1	Yes 2 Na	28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,			
Δ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	cian: To the best of my left: On the basis of exami	ination and/or investi	gation, in my opinio	n, death occurred a	t the time, date and I	place, and due to the ca	use(s) and manner stated			
	To t with To t		29b. Signature and title of certifier	1		29 c. License	2)36	290	d. Date signed (Month,	Day, Year)			
7			30. Name and address of person who can	apleted cause of death	(Item 23a) (Type, P	rint) Dr.#4	III Tou	uson M	D 21204	<i>L</i>			
	Stat	-	31. Date fied (Month, Day, Year)	32. Registrar's S	- L-1-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Reg. No Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death CXTUBER Physician/ 0300 00 2010 Medical 4c. County of Death 4a. Facility Name (in no institution, **Examiner** DalTimore ita 8. Date of Birth 12/31/1968 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days 1 ፟፟፟፟ M 2 □ F 216-98-3748 Yrs 41 **Director** Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Reisterstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 U.S.A. 638 Glynita Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 😡 Never Married 2 🗌 Married ☐ Yes 2 🛭 No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Security Install Se1f 12 Employed Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Williams Betty Robert L. Royal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 Glynita Circle Reisterstown, MD Betty J. Royal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 10/14/2010 Hampstead, Maryland Are of Funetal Service Licensee 22. Name and Address of Facility . Signat 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 J. Wayne Osterling 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Se (Fin I disease or condition Physician/ Medical resulting in death) Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 1 Yes 2 Q cate has been signed by the a page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 2 No Other: 2 1 🗌 Yes 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier f examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis 3 🗆 ing Nurse Certif Praction only one) 29b. Signature and title of 29d. Date signed (Month. Day, Year) 0068 2010 ause of death (Item 23a) (Type, Print) Name and address of person who con 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Manyland / Department of Health and Mental Hygiene Registrar

State of Manyland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0 4 Month 09 AM Radcliffe 010 Marv Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Good HOSPITAL Baltimore, n/a Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 219-40-7652 Day, Y Country) Director 67 y8,1943 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD 1 X Yes 2 No n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 4613 Marble Hall Rd 21239 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8yrs. Case Worker HospitalSupportServ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tinsley Anna Hairston Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Radcliffe/husband 4613 Rđ. 21239 Marble Hall Balto. Mđ John Α. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sept.10,2010Balto.,Md OakLawnCemetery 21. Signature of Juneral Sovice Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL
1412 E. PRESTON ST. BALTO 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Subarachnoid Hemorrhay disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OVED BLANK LEX Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-trail that initiated events CERTIFICAT Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 19 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 24 hours after death. **Puneral Director:** After this certifics leted filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Acciden
Suicide Investigation 6 Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uzvam RES 000 09/04/2010 no completed cause of death (Item 23a) (Type, Print) Loch Raven Blv. Baltimore, MD, 21239 5601 32. Registrar's Sig State

Registrar

adcli

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Emerson P. Ruffin	S 1- For State	tate of Marylar		nent of l		Mental H			3235
Physician/	Registrar 1. Decedent's Name (First, Mide	dle,Last)					2. Date of Deat		3. Time of Death
Medical Examine		Ruffin					Month October 8,	Day Year , 2010	0800 hrs
	4a. Facility Name (if not instituti	on, give street and num	ber)		. City, Town, or Lo	ocation of Death			
	1510 North Pulaski S	treet			Baltimore		N/A		
Funeral	5. Social Security Number	6. Sex 7.	. Age (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24Hrs	-	th(MM/DD/YYYY) 9. Bii Forei	nn
Director	214-68-3480	1XM 2 F	54	Yrs.	Months Days	Hours Min	08/17/1956 Country MD		
	Usual Residence of Decedent		1.0.00						
w any	10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits 1 X Yes 2 No
-f she	MD N	/A			Baltir	more			
the Maryland a or 28a-f sh tified at once Director					10f. Zip Code	045	110	Og. Citizen of What Cou	ntry?
	1510 N. Pul			1 20 111		217		U.S.A.	
r death with or items 23 - must be no	1 Never Married 2 N	Married Armed Ford			Decedent of Hispa , specify Cuban, f			White, etc.	ican Indian, Black,
ter death	3 Widowed 4 X Di	1 Yes vorced If Yes, Give Year	2 No	1□ v	es 2X No	specify:		Specify: Bl	ack
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examine. To Be Completed by 1	45 December 12 Education (Sp.	or Dates:	completed) 16a		Usual Occupatio		work done	16b. Kind of Business/	
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2121 2121 Mental F marked ie event, To Be	Albert S. R					-	Watso		
hould hould Me is ma hties	19a. Informant's Name/Relation		- 1					ber, City or Town, State	
MD and 2 sho alth and 27 is	Jessie Ruff	in(mother						timore,MD	
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatif	one) 2 Medical Ex	aminer: On the basis of and manner stat		r investigation	n, in my opinion, o	death occurred	at the time, date a	and place, and due to the	e cause(s)
	29b. Signature and title of certific				29c. License			29d. Date signed (Mo	nth, Day, Year)
1	Lament route	with me			O.C.M	.E.		October 9, 2010	
100	30. Name and address of person			•	D 6: :	D. W	4D 04654	-	
	Parhela E. Southall, I	Assistant M	edical Examin	er 111	Penn Street,	baitimore, l	VID ∠1201		
State Registra		5 2010 172	strar's Signature	da	MI				

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Examin		Dove	16056				Wess		er		c. County of Dea	110
Funeral Director		5. Social Security No. 188–32–71 Usual Residence of	43	. 🗀 🖂	ge (In yrs. Ia 70	ast birthday, Yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth ay, Ye <i>ar</i>) 19	9. Bi	irthplace (State or Foreign ountry) PA
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rs after dea iral", or itel Examiner	þ	11. Marital Status1 Never Marri3 Widowed		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		5. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	an, Mexican, Puer	pecify Yes or No to Rican, etc.)	-	14. Race - Am Black, Whi Specify: wh	ite, etc.
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Certificate:	27. Manner Death 1 Matural 2 □ Accident 3 □ Suicide	5 Pending Investigati 6 Could not	he I	y, Year)	28b. Time o injury	M 1 □	y at	28d. Describe			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32358 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Estella 15 Medical 4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice Examiner 4h City Town or Location of Death 4c. County of Death Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2🛣 F 220-24-9225 Days (Month, Pay, Year) 9/3/1929 81 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3600 West Franklin Street 21229 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify:Black 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Farrell Mamie Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 West Rogers Ave., Baltimore, MD 21215 Connie Brooks Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 10/15/2010 Woodbine, MD 21. Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility

Maryland C
PO Box 141 remation Services 3. Baltimore, MD Maushan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence on Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the autopsy performe 2 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🎜 No Other: ဂ 1 🗌 Yes 4 Nursing Home 5 Residence 6 A-Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death.

The Funeral Director: Af oleted filled in by the funeral black filled in by the funeral black filled in by the funeral black funera 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Professional: The basis of my knowledge, are in manner as that due to the cause(s) and manner as stated. completed (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Data filed (Month Day, Year, 15 2016) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G908, 10/15/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No2 32359 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rudmun OCTOBER Liva , 2010 1:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖫 F Country) 1270471916 Director 130-09-9246 Yrs 93 AUSTRIA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD MONTGOMERY BETHESDA 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6008 MANOR OAK WAY 20814 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOUSEWIFE OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. မ HERMAN WEINTRAUB PAULINE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLEN RUDMAN/SON 6008 MANOR OAK WAY, BETHESDA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) LEBANON CEMETERY | 10/15/2010 GLENDALE, NY 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ HYPOXIC RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner LEFT LOWER-MIDDLE-UPPER LOBE PNEUMONIA Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, CONGESTIVE HEART FAILURE, CORONARY ARTERY DISEASE, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown RECURRENT PNEUMONIAS, RECURRENT URINARY TRACT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? 1 ☐ Yes 2 🕅 No death? INFECTIONS. Vita 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MUNION 0068405 10/13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u> Jesus Guevara-Nieto Suburban Hospital</u> Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 152010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 15 30 PM CHARISA DEANE SHACKLEFORD 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Rosedale Square Bullimore FRANKLIN HOSPITal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Yrs. Director 217-11-5163 39 Pennsylvania 29, 1970 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Evanither must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9900 Dehaviland Way Apt. B 21220 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Completed by Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Disabled Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Gary Hedges Kern Norma Gail Wynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Health a Norma Tilton / Mother 313 Fords Lane, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 5 Other (Specify) Hilltop Service Corp. 10-11-10 Towson, Maryland of Fure al Service Lice McConasaTuneral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 flong that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complications, or heart failure. List only Immediate Cause (Final **Physician** noid hemorrhage Subarac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the buriai-trai Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical as use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 □No 1 ☐ Yes 2 P No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred al or Attending F after death. Division 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05/2010 3666

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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			For State	State of M	-	epartment of		Mental Hygie	ene	0 00001
			Registrar 1. Decedent's Name (First, Middle, La	ast)		Certificate of	Death	2. Date of Death	g. No. 🚄 📗	U 3/361
P	hysicia		, , , , , , , , , , , , , , , , , , ,	Linnie	Q,	mith		Month 10 1	1 2010	3. Time of Death 16:55
~~	Medic Examin		4a. Facility Name (if not institution, given				or Location of Death		4c. County of De	
- Long to			Gilchrist Ces	nter		Tow	Son		Ba/to	
	uneral			Sex 7. Ag	e (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. E	lirthplace (State or Foreign Country)
Di	irector		220-88-9939 Usual Residence of Decedent	- W-ZAN	45 Yrs	5.		(Month, Day, Ye	1964	Country) MD
and	show	ō	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits
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h the	Sa or be n		10e. Street and Number	1		10f. Zip Code	2.0	109	g. Citizen of What	
21215-0036 within 72 hours after death with the Maryland riene.	ms 2; must	Funeral	310 E. 204 S		Turne in LLC		218	anifu Van er Ne	USA	
or dea	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☑ Married	12. Was Decedent B Armed Forces? 1 \(\sum \) Yes 2 \(\sum \)		 Was Decedent of I If Yes, specify Cub 	an, Mexican, Puerto	Rican, etc.)	14. Race - An Black, Wh	ite, etc.
033 rs aft	ıral", I Exar	edk	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2X No	Specify:		Specify:	Black
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HVQ	other ent, t	Be	12th Grade 17. Father's Name (First, Middle, Last,)		awar er	18. Mother's Nam	ne (First, Middle, Mai	iden Surname)	
land be filed fental Hv	rked tic ev	욘	Fred Evan				Margar	1	145	
Maryland 2 should be filed	is ma auma		19a. Informant's Name/Relationship		19b. M	lailing Address (Street	and Number or Run		ity or Town, State, 2	Zip Code)
	item 27 other tra		Malcoly Smith	-Husbane	10.	E. 20th		1	21218	
7 7			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		cemetery,	isposition (Name of crematory or other pla	ce) !		Oc. Location - City of	· · · · · · · · · · · · · · · · · · ·
Baltimo permit. Page Department	Important: If any injury or once.	- 5	4 ☐ Donation 5 ☐ Other (Special Service Lice)		Triniy	22. Name and Addre		o-2010 13	3a /tu, M	I D
Dep.	lmpor any in	Н	Hartle	5 K. Im	(,)	1101 E.			•	MD 21202
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do not					Approximate
Phy	sician/	e y	Immediate Cause (Final disease or condition	LVN		new				Interval Between Onset and Death
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		er	Sequentially list conditions,	b. Due to for so	a consequence of:					
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eate be	physician and the burial-transit	dical	•	d						
387(ing ph e as th		IF FEMALE:		,				T	
Box 687 death certifica	for us	sian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of o	lelivery Day Year
. . . .	y the	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	t time or death	o in other (specify)				
P.O.	ned b	y P	Part II. Other significant conditions	contributing to death b	ut not resulting in t	ne underlying cause g	iven in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
ds, quires	en sig	ted t						1 Yes	2 🗆 No 3 🗆	Probably 4 🗆 Unknown
aw rec	as be	Completed by						24a. Was an autopsy	prior to	autopsy findings available o completion of cause of
He l	certificate has t	Co						performe 1 \(\sum \) Yes 2	d? death? No 1 □ Y	es 2 🗆 No
ician	certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:		Oth	lace of Death (Chec		> -	la 405 mil 4 m
Division of Vital Records, tal or Attending Physician: The law requires rs after death.	er this eral di	e: 10	27. Manner of Death	28a. Date of inju	ent 2 ER/Outpa ry 28b. Tim	e of 28c. Inju	4 □ Nursing Hory at	ome 5 Residence 28d. Describe how		ecify) NOSPILE
on (r: Afte	icat	1 Natural 5 Pending 2 Accident Investigation		<i>r, Year)</i> inju		k̂? Yes 2 □ No		,,	
VISION After de ter de	irecto by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			street, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
Dival o	eral Di									
e Hosp	To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exar	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination and/or in	vestigation, in my opini	on, death occurred a	t the time, date and p	place, and due to the	e cause(s) and manner stated.
To th e within	To the	2	29b. Signature and title of certifier		2001 01 11 7 11 10 11 10 11	29c Licens			I. Date signed (Mor	nth, Day, Year)
			Marin	$\sim \sim 2$			5830	3 0	CTUSER	12 2010
_	8		30. Name and address of person who	completed cause of d	eath (Item 23a) Typ	G 701 C	s. Cha	nles (1	Ton3	12 2010 ov mg
	Stat Registra	e	31. Date filed (Month, Day, Year) OCT 15	The state of the s	's Signature	2000				
	region (061 10	UIVI The	us fi.	Market				

		•	For State Registrar		State of Ma	aryland		tificate				Reg. No	71111	-	32362
	Physicia		1. Decedent's Name Walt		st) A. Skork	.0.	Sr.				2. Date of De		y, 2010		Time of Death
	Medic Examin				street and number)			4b. City, To	own, or Loc	cation of Death			. County of Dea		
			Ste]		s Hospice				imoni				Baltir		
	Funeral Director		5. Social Security Nu 218-01-03 Usual Residence of	308	XIMODE	(In yrs. las	st birthday) Yrs.	If Under 1 Months		Under 24 Hrs. l lours Min.	8. Date of Bir (Month, Da May 26	th ly, Year) 19	9. Bi	rthplace (ountry) lary	(State or Foreign Land
	and s how dat	tor	10a. State	10b. County		10c. City,	, Town or Loc	ation						10d. In	side City Limits
	Maryl 28a-f otifie	Director	MD	Baltim	nore		Ran	dalls						1	☐ Yes 2 🛣 No
	th the	al D	10e. Street and Nun		_			10f. Zip (10g. Ci	tizen of What C	ountry?	
ď	ath wif	Funeral	4527 A	Allen Roa	12. Was Decedent E	ver in IIS	13 V	Vas Decedel	2113		cify Yes or No.		U.S.A. 14. Race - Am	arioon Inc	dian .
11:03 a.m. 215-0036	e filed within 72 hours after death with the Maryland ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by		ied 2 Married 4 Divorced	Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates.			Yes, specify		nic Origin? (Spe lexican, Puerto l pecify:	Rican, etc.)		Black, Whi		
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	and 2 s Health tem 27 other tra		Deborah A 20a. Method of Disp		1hofer Daugh	20b. Pl	ace of Dispos	Aller sition (Name	of	Т	allstow Date		ocation - City o		State
OBE			1 🔀 Burial 2 ☐ 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State	Mea	emetery, crem dowrid	atory or oth ge Mei	er place) m. Pa	rk 10/	16/10	E1.1	kridge,	Mar	yland
OCTOBER Baltimore,	permit. Page Department Important: I any injury or		21. Signature of Fur	neral Service Licen	See .	_	22	. Name and	Address of				erstown town, M		d 1136
					nplications that caused one cause on each line.		. Do not ente	r the mode	of dying, su	uch as cardiac o		_		Appi	roximate val Between
	Physician/	200	Immediate Cause (disease or conditio	Final	PROSTA		ANCER								et and Death
	Medical Examiner		resulting in death)	•	Due to (or as a	conseque	ence of):								
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0	icate be executed gphysician and sthe burial-transi	edical Examiner	that initiated events resulting in death) l	S	Due to (or as a	conseque	ence of):								
3760	ficate g phys				d							-			
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pro Other (spe					23d. Date of de Month	elivery Day	Year
P.O.	requires that the been signed by the should be detach	by Ph	Part II. Other signif	ficant conditions	contributing to death bu	ut not resu	ulting in the u	nderlying ca	use given i	in Part I.	23e. Did 1	obacco	use contribute t	o the cau	use of death?
RKO ds,	quires en sign	ted k									1 🗆	Yes 2	No 3□1	robably	4 Unknown
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Re Se	sician: The law certificate has rector, page 2 s		05.14				_				perf	2 X N	o 1 🗆 Ye	s 2 🗆	No
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WA.	ding Physician: h. After this certific funeral director,	e: To	27. Manner of Death	h	28a. Date of injur (Month, Day	у	28b. Time of injury		c. Injury at	1 Nursing Ho	me 5 L Hesi 28d. Describe			сіту)	HOSPICE
	endin eath. or: Aft the fur	ficat	1 X Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigatio 6 ☐ Could not I	in			М		2 🗆 No					
Division	tal or Attenres after deat al Director: ed in by the	al Certificate:	4 Homicide	determined		ry - At hor . (Spec <i>ify)</i>	me, farm, stre	et, factory,	office		28f. Location (City or To		d Number or Ri	ural Route	e Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	Medical Exam	vsician: To the best of r niner: On the basis of ex se Practioner: To the b	kamination	and/or invest	igation, în m	y opinion, d	leath occurred at	the time, date	and place	e, and due to the	cause(s)	and manner state
_	Veith Com		29b. Signature and	title of cottifier	Male			29c.1	License nur	mber		29d. Da	ite signed (Mon	Day, Y	(ear)
	•		30 Nama and	NUG	completed cause of de	agth (Itam	23a) /Tuno D	rint)	1177	170		/	0/13/	W	0
54	1		/	JONES, CI	RNP 2300 D	ULAN	EY VAL	LEY R	р. т	'IMONIUM	. MD 21	093			
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DHMH 17 Rev 7/2009

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OCTOBER 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2870 130 P M DIMPKINS Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City, **Examiner** WINCOPIN Circle alumbia HOWARD 7. Age (In yrs. If Under 1 Year If Under 24 Hrs. Social Security Number last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Waskington, DC Months Days Hours Min 6 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Completed by Funeral Director Howard Mb 1 X Yes 2 No olumbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a or ner must be n 2104 U.S.A WINCOPIN 10205 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ö Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than 'traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Count 90Vernmen1 WORKER. xcial Be 18. Mother's Name (First, Middle, Maiden Surname) WILKINSON 19a. Informant's Name/Relationship (Type, Print husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/0444 10205 WINCOPIN Circle DIMPKINS Health tem 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ō 1

■ Burial 2

Cremation 3

Removal from State COLUMBIA, Polumbia Mens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to minimaliate cause. Enter Underlying Examiner Due to for as a noneequence cry as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 🔼 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural
2 Accider 5 Pending s after death. 1 🗆 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completed fi 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 ChurtER DR LEE MD EDWARD

OHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regierar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark Saunders	State (1- For State Registrar	of Maryland / Departme <i>Certifica</i>	ent of Health and Ment ate of Death	al Hygiene Reg.	No. 2010 3236						
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)			Date of Death Month October 12,	3. Time of Death 2010 1025 hrs						
	4a. Facility Name (if not institution, give		4b. City, Town, or Location of Bel Air	Location of Death 4c. County of Death Harford							
Funeral Director	5. Social Security Number 6. Sex 217-60-1567	7. Age (In yrs. last birth	nday) If Under 1 Year If Under Months Days Hours	Faraign							
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits						
faryland 18 tonce	MD Harford 10e. Street and Number	Bel A		1100	1 Yes 2 X No Citizen of What Country?						
th the Maryland 23a or 28a-f sho notified at once al Director	3808 Hazel Ct		10f. Zip Code 21009		SA						
er death wi	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year		Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Ves 2 V No specify:							
nours after and an antural and by	15. Decedent's Education (Specify onl	or Dates: y highest grade completed) 16a. D	Decedent's Usual Occupation (Give k		Specify: White 6b. Kind of Business/Industry						
5-0036 ed within 72 hours a tygient from "natura the Medical Exemite Completed b	Elementary/Secondary (0-12)	College (1-4 or 5+)	or	Food & Bev. Indust.							
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Albert W. Saunder	s	s Name (First, Middle, Ma e M. Kammer	iden Surname)							
D 212 should be and Ment 'is mark	19a. Informant's Name/Relationship (Ty	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co									
e, MD :	20a. Method of Disposition										
Baltimore, MD 212 permit. Pages I and 2 should be Department of Health and Ment Important: If item 27 is mark injury or other traumatic even	1 Burial 2 X Cremation 3 Donation 5 Other Specify:	Baltimore, MD									
Ball permit Depar Impo	21. Signature of Funeral Service Licens Burn G. W.	ille	Inc 610 W. MacF	hail Rd Bel							
Physician Medical	23a. Part I. Enter the disease, or complifailure. List only one cause on each	ch line.	t enter the mode of dying, such as ca	ardiac or respiratory arrest	t, shock, or heart Approximate Interval Between Onset and Death						
caminer	or condition resulting in death)	Asphyxia Oue to (or as a consequence of):									
ner	Sequentially list conditions,	nhalation of Car Exhaust Oue to (or as a consequence of):									
d sit	(Disease or injury that initiated C	Oue to (or as a consequence of):	-								
60, are be executed by sician and ne burial - transit Medical Examine	d. UNPENDED	AMENDED									
3760, ficate be g physici s the buri	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic	pregnancy	23d. Date of delivery Month Day Year						
b. Box 6876 the death certificat by the attending phy ched for use as the Physician/M	past 12 months? 1 Yes 2 No 9 Unknown	Pregnant at time of death 5									
P.O. Bs that the digned by the detached by Phy	Part II. Other significant conditions	The state of the s	g in the underlying cause given in Pa		acco use contribute to the cause of death?						
ds, P equires the een signs build be designs steed by				24a. Was an							
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Pertification: To Be				autopsy perform 1 Yes 2	ed? death?						
ital Recidina: The scertificate rector, page	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 ✔ ER/O	26.Place of Death		esidence 6 Other:						
ng Physing Physical After this Unertal dir	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	Fime of Injury 28c. Injury at Work	? 28d. Describe ho	w injury occurred hed car exhaust						
ision Attendi	1 Natural 5 Pending 2 Accident Investigation	Oct 12, 2010 0940		No ,	reet and Number or Rural Route Number, City						
Division o spital or Attending tours after death. neral Director: Aft filled in by the function: Certification:	3 Suicide 6 Could not be determined	(Specify) Garage			urt, Abingdon, MD						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	29a. Certifier 1 Certifying Physiciane) 2 Medical Examiner	an: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	ath occurred at the time, date and pla nvestigation, in my opinion, death oc	ice, and due to the cause(curred at the time, date ar	(s) and manner as stated. Indicate place, and due to the cause(s)						
T S T S	29b. Signature and title of certifier	D 00	29c. License number O.C.M.E.		29d Date signed (Month, Day, Year) October 13, 2010						
	30. Name and address of person who	completed cause of death (Item 23a)	les on the	757							
State	Patricia Aronica-Pollak MD	Assistant Medical Exam		Iltimore, MD 21201							
Registra		O Server B.	pair								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Rhoda 804 AM 10 Somers 2010 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death Square Hospital Rosedale BalTIMORE FRANKLIN Date of Birth (Month, Day, Year) Feb 07, 1922 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 88 Months Days Hours 1 M 2 KF Maryland 213-16-9412 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h. County 10a State Middle River 1 NYes 2 □ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21220 United States 127 Trailways Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceuci... Armed Forces? ¹□Yes 2 (X)No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Home Health Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Waskins Dorothy Jack Carroll Asner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8001 Stratman Road Dundalk, MD 21222 Sherry Davis /Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct 14 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2010 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. NaGrennatories not anidy Funeral Alternatives Signature of Funeral Service Licensee M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Erfter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular ACUTE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannes of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, certificate this

Examiner burial-trar attending physician for use as the burial signed } cate has page 2 s director, Certification: To After thi funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f shov ust be nutfilled at

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7 is marked other than "natural", or items traumatic event, the Widcel Eventing.

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Physician

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Maryland 21215-0036

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Medical

3 Suicide

29a. Certifier (Check only one)

4 Homicide

n 24 hours after death.

ne Funeral Director: Aft
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State

one)	and manner stated.
9b. Signature ar	d title of certifier
•	Il form
	() Truy)
). Name and ad	dress of person who completed cause of death
20	11 17 0

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

D0062573

10/13/10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print)

Square OR Balto md 21237 FRANKLIN 4000 Debra Huttens

Registrar

31. Date filed (Mont)

6 Could not be

determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar			ealth and Mental	9	32366
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or	2. Date of Month 5 - 5	Day Year 26 20 / C	2256 M
Funeral Director	5. Social Security Number 6. Sex 12 M Usual Residence of Decedent	7. Age (In yrs. last t		If Under 24 Hrs. 8. Date of (Month)	of Birth h, Day, Year)	rthplace (State or Foreign country) ennsylvania
e Maryland a-1 ehow utiled at	10a. State 10b. County MD Montgome:		wn or Location Wheato	n		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28a-1 show sumatic event, tra Medical Evaration must be notified at TO Be Completed by Funeral Director	10e. Street and Number 11502 Narin Rd. 11. Marital Status 12. W	as Decedent Ever in U.S.		902 spanic Origin? (Specify Yes o	10g. Citizen of What Countries Store 14. Race - Am	ates
5036 nours after death v ural; or iteme 238 LEvarificat must d by Funeral	1XXVever Married 2 Married 1	rmed Forces? ☐ Yes 2 No Yes, Give ear or Dates:	1 ☐ Yes 21 No	spanic Origin? (Specify Yes on the Mexican, Puerto Rican, etc.) Specify:	Specify: Ţ	ite, etc. Vhite
Maryland 21215-0036 to 2 should be filled within 72 hours aft the and Mental Hygiene. 27 is marked other than "natural", or treumatic event, the Medical Exact To Be Completed by F	15. Decedent's Educatior (Specify only highest grade con Elementary/Secondary (0-12) C	16 ppleted) ollege (1-4or 5+) 5+	a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired) Researcher	tion uring most of working	Medical / Head Inju	
aryland 2 should be filed v and Mental Hygie marked other umatic event, II	17. Father's Name (First, Middle, Last) John Joseph	n Shuste	i	18. Mother's Name (First, Mi Phyllis		
≥ 5€75	19a. Informant's Name/Relationship (<i>Type</i> , P Carole Firestone / 20a. Method of Disposition	Sister	• •	nd Number or Rural Route Now Wood Pkwy.W. Date		Lx, AZ 85048
Page nent c ant; if	1 □ Burial 2 ☑ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service-Licensee	l comot	apeake Cremato apeake Cremato	ory 10/13/201	0 Beltsvil	
Balti permit. Depertr imports eny inju	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	un.	933 G1St A	s of Facility al and Cremat: Ve., Silver Si , such as cardiac or respirato	pring, MD 2	20910 Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions b.	Due to (or as a consequence	e of):	2177		Onset and Death DM
68760, tificete be executed g physicien end as the burdel-trenst ledical Examiner	cause. Either Underlying Gause (Liberaso of Injury) that initiated events resulting in death) Last d					
death cer e ettendin d for use	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal deat □ Pregnant at time of death □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	elivery Day Year
Cords, P	Part II. Other significant conditions contribut	ing to death but not resulting	in the underlying cause giver		Did tobacco use contribute t	o the cause of death?
	25. Was case referred to medical	·····		1 T	autopsy prior to death? es 2 No 1 Ye.	utopsy findings available completion of cause of s 2 No
2 t 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	examiner? 1 Yes 2 No Hospit: 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EH/C	Outpatient 3 DOA Other Time of 28c. Injury Work?	at 28d. Descr	niy one) Residence 6 ⊡Other (Spe ribe how injury occurred	acify)
Division contending Polital or Attending Ports effer death. Paral Director: After tilled in by the funeral Illed in by the funeral I Certification;	4 Homicide	e. Place of Injury - At home, building, etc. (Specify)	,	City or	on (Street and Number or R r Town, State)	
To the Hospital of within 24 hours et To the Funeral D completely filled in Medical Cel	(Check only 2 Medical Examiner: C	on the tasis of examination and mariner stated.	and/or investigation, in my opi	o, date and place, and due to nion, death occurred at the tinumber	the cause(s) and manner a me, date and place, and du 29d. Date signed (Mon	e to the cause(s)
	30. Name and address of person who complet	ed cause of death (Item 23a		Hawkes	mo 209	2010
State Registrar DHMH 17 Rev 1/2001	31. Date filed (Month, Day, Year) OCT 15 2010	32. Registrar's Signature	Jack!			ı

20732

1 ☐ Yes 2 No Specify:

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country?

USA

14. Race - American Indian,

Specify: Black

10f. Zip Code

"natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic events. Baltimore, Maryland 21215-0036

For State Registrar

10a, State

MD

11. Marital Status

10e, Street and Number

4950 Chavez Lane

1 Never Married 2 Married

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give

Director

Funeral

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Physician/

Medical

Examiner

Funeral

Director

Physician/ Medical Examiner

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusinan and within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page

Division of Vital Records, P.O. Box 68760

ed	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🏝 No	Specit	fy:		Specify: B.	lack
plet	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done	ation during mo	st of working	16b.	Kind of Business	s Industry
Completed I	Elementary/Seconday (0-12)	College (1-4 or 5+)	7	ife. DO NOT use retired) Electric				Constri	ıction
To Be	17. Father's Name (First, Middle, Last)			BIECTI I			irst, Middle, Maide a Fairf		de e i on
욘	Rudolph Smi	th 				Enola	a Fairf	ax	
	19a. Informant's Name/Relationship (T) Janice Carter-	ype, Print) Smith/Wife	19b.	Mailing Address (Street 4950 Chave	and Numi 22 L	ber or Rural Ro ane,	oute Number, City of Chesape	or Town, State, Z ake Bea	ach, MD
	20a. Method of Disposition 1 Durial 2 Commation 3 D		Place of cemetery	Disposition (Name of y, crematory or other place	ce)	Date	e 20c.	Location - City o	r Town, State
	4 Donation 5 Other (Specif	_(y) F		Journey Cr	em.	10/15/	′2010 W	codbine	, MD
	21. Signature of Funeral Service Licens	Dorota Marsh		22. Name and Addre	ss of Faci and X	Czema Czema	tion Se	Evines	21203
1	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition	plications that caused the de		ot enter the mode of dylr	ng, such a	s cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Dowth
	resulting in death)	Due to (or as a conse	quence of	f):					
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	auence of	fì·					
m E	Cause (Disease or linjury	Due to (or as a conse	querice o	17.					
Ĕ	that initiated events resulting in death) Last	Due to (or as a conse	quence of	f):					
dica		d							
/We	IF FEMALE:	23c. If yes, outcome of preg	nancy						
Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fe 4 Pregnant at time o	etal death	3 ☐ Ectopic pregnant 5 ☐ Other (specify) _	су			23d. Date of de Month	elivery Day Year
y Ph	Part II. Other significant conditions co	ontributing to death but not r	esulting in	n the underlying cause gi	ven in Par	t I.	23e. Did tobacco	use contribute t	to the cause of death?
ted b							1 🗌 Yes	2 □ No 3 💢	Probably 4 🗌 Unknown
nple							24a. Was an autopsy	prior to	utopsy findings available completion of cause of
ပ္ပ							performed?	death?	es 2 🗆 No
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖾 No	Hospital:		Toth	or.	eath (Check on			
e: 10	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Ti	ime of 28c. Injur	4 🗆 1		5 Residence . Describe how inju		cify)
icat	1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		inj	jury worl M 1 □	? Yes 2	_	,	.,	
Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farr ify)	m, street, factory, office		28f	Location (Street a City or Town, Stat	nd Number or Ri e)	ural Route Number,
Medical	(Check 2 L. Medical Exami	sician: To the best of my kno iner: On the basis of examinat	on and/or	investigation, in my opini	on, death	occurred at the	time, date and plac	e, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier	. 14*		29c. Licens	e number		29d. D	ate signed (Mon	th, Day, Year)
	Mulsh of De	Mon M	<u>v</u>	106	42.	34	100	34er 14	, 2010
	30. Name and address of person who of the state of the st	completed cause of death (Ite	m 23a) (T	ype, Print) Woodyara	1 Rd	. Ste	101 Ch	nton, l	40 20735
e r	OCT 15 2010	32. Registrar's Sign	aure						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month Richard Harry 2010 10:00PM October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hart Heritage Estate Street Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F July 5, Year 1920 Sweden Director 90 127-01-5130 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 HNo Whiteford Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21160 USA 1205 Old Pylesville Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Black, White, etc. 1 X Yes 2 🗌 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", Specify: 3 ₩Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Education Teacher +6 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Freida Karlson Richard Leonard Sward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 1205 Old Pylesville Road, Whiteford, Maryland 21160 Ronni Casey / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Lakeview Cemetery 10-19-10 Jamestown, NY 21. Signature of Funeral Service License McComas Funeral Home, P.A. Dartwasci (athleen) 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ KNO disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law page 2 s certificate has performed? Yes 2 No 2 🗆 No 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify Assisted 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Living 1 Natural 5 Pending work? 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Certifying Prysidant: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 123a) (Type, Print) 615. W. MACPHAIL BELDIN MA 21014 LGRAD precis

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER. 2010 SCHULMAN 3:45 P™ ROBERTA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE 6500 GARDENWICK ROAD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Birtnpic Country) NJ **Funeral** 1 □ M 2 🛛 F Months Days 01721^x/1928 82 Yrs. Director 158-20-4618 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City. Town or Location Examiner must be notified at 10a. State Director 1 Yes 2 No 28a-f BALTIMORE MD BALTIMORE 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? Funeral 23a USA 21209 6500 GARDENWICK ROAD 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 10 by 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) ART TEACHER EDUCATION Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever d Mental I ပ COHEN COHEN ANNA SAMUEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3427 TERRAPIN ROAD, BALTIMORE, MD 21208 BARBARA KROLL / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING SOLOMON 10/12/2010 CLIFTON, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final YM AHOMA Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 1 Yes 2 G g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 🗹 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 🗌 Yes 2 🗌 No 1 Natural 5 Pending М Accident Investigation Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 9105 FRANKLIN SPIM 30. Name and address of person who completed cause VELZING

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ NODGRASS 0020M 2010 Medical Examiner 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Harwood Anne Arundel 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 12, **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min 1<u>944</u> Director Indiana 303-48-8798 65 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "nother "nother than 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🖵 No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2804 Ritchie Road 20747 United States 11. Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 XNo Specify Completed 3 Widowed 4 Divorced Year or Dates. 1962–66 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Don Snodgrass Mary Ann Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Jay Snodgrass/son 364 Leland Avenue Shreveport Louisiana 71105 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 10/16/2010 Woodbine, Maryland 21. Sign to re of Funeral Service License 22. Name and Address of Facility Ding Home Cremation Service P.O. Box 784 M00957Beverly L. Heckrotte, P.A. Clarksville, M uanita MD 21029 23a. Part NEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate !
completed filled in by the funeral director, pag Yes 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? +OSPICE 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how injury occurred 5 Pending injury Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 114 Name and address of pers pleted cause of death (Item 23a) (Type Rrint) MICHARL Am

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

0-07678 Ielinda Stevens		Please Type or Print in Black Indelible Ink. Ensure All Copic State of Maryland / Department of Health and Mental H		gible.2010	3237						
Physicia		1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat		3. Time of Death						
Medical Examin		Melinda Rose Stephens	Month October 6		0910 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 9813 Bethesda Church Road #104 Damascus	h	4c. County of Death Montgomery							
Funeral Director		5. Social Security Number 219-86-4231 Output 6. Sex 1 M 2 K F 37 Yrs. Fruit Fruit Control of Decedent 7. Age (In yrs. last birthday) Months Days Hours Min Usual Residence of Decedent	n.	th (MM/DD/YYYY) 9. Bir Foreig 2, 1972 Co							
daryland 28a-f show any 1 at once.	10a. State 10b. County 10c. City, Town or Location										
e Maryl or 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country									
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2121 wild be fil Mental B marked c event,	Be L	Howard LeRoy Stephens Carole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Informant's Name/Relationship (Type, Print)	Sue	Olive	Zin Code)						
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Baltimore, permit. Pages 1 ar Department of Hes Important: If iten injury or other tr	ŀ	21 Signature of Funeral Service Licensee Tinal Journey Crematory 10 22 Name and Address of Eacility GOING Home Cremati	0/13/201 Lon Serv	Woodbine	Maryland × 784						
Physician	1	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arre	Clarksv11 est, shock, or heart	Approximate Interval						
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Morphine and Diphenhydramine Intoxion of the condition resulting in death) Due to (or as a consequence of):	cation		Between Onset and Death						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
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executed an and il - transit	ਜ਼⊦	d. X UNPENDED	9-10 vt								
h co		# las notated.perME.G908.10/27/ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnated by the last of the pregnant at time of death 4 Pregnant at time of death 5 Other (Specify)	2010.WS	23d. Date of delivery Month D	lay Year						
D. Bo t the deat by the at ached for	≥L	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	he cause of death?						
P.O.	≦		1 Yes	2 No 3 Prob	abiy 4 🗸 Unknown						
Records, The law require ficate has been si , page 2 should b	Completed		24a. Was a autops perform	sy prior to c m <u>ed</u> ? death?	oppsy findings available ompletion of cause of s 2 No						
ital Recician: The scertificate rector, page	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Nursing		Residence 6 🗸 Other	Sanna						
Division of Vital tal or Attending Physician is after death. al Director: After this certified by the funeral director.	앍	1 Yes 2 No II Injury 22 ENOutpatient 3 DON 4 INdisin 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	Occile						
tendin death. tor: A	Certification:	Natural 5 Pending fd 10-6-10 fd 9:00am 1 Yes 2 x No	unknow								
Divising pital or At ours after derail Direct filled in by	틝	3 Suicide 6 X Could not be determined (Specific) Specific Specific)		treet and Number or Runate) 9813 Bet							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	d due to the cause	e(s) and manner as state and place, and due to the	d.						
To wit	ĕ	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	th, Day, Year)						
		Panatif (puthall, M) O.C.M.E.		October 7, 2010							
Ø V		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201								
Sta Registr	te ar	31. Date filed (Month) Per Year 5 2010 32. Registrar's Signature									
DHMH 17 Rev 1/200 OCME 2006		ORIGINAL		OCME							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM 1222 4 KNE Medical Facility Name (If not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death MediCAL tiMORE Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Hours Min 215-26-2561 August 19,1931 Marviand Director 79 Usual Residence of Decedent show 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Perry Hall 1 Yes 2X No Baltimore Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21128 5043 Glenside Manor Drive n "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Completed by 1 Never Married 2 Married Yes, Give 2 No Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Millwright Carpenters Local 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Sterling Charles T. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5043 Glenside Manor Drive, Perry Hall, MD. Donna DePazzo Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 15, 2010 Baltimore, MD. 21. Signature of Funeral Service Licensee Z Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit Exam The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the detached 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate Yes 2 No 1 Yes 2 No or Attending Physician: completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No 1 Natient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25723 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North GREENE Street Baltimore MD 21301 velasco 31. Date filed (Month, Day, Year) State 32. Registra Signa 1 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ber 2:00 AM 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltimore lace Windsor 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth

(Month, Day, Ye If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 M Min. Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City, Limits Director Homor 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral items 23a 124 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 3 No Maryland 21215-0036 1 Yes 2 No "natural", Specify: Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ability Kamines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/8 St ittom 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lic 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Atheroscheestic Physician/ DISEase disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner sactor tially lict conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phone IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe 2 X No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32158 13 0 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Ewtzy) st, ste 407 821 N. Juoth 2/201 rai 31. Date filed (Month, Day, 32. Re State

ORIGINAL

Registrar

DHMH 17 Rev 7/2009

Natasha	Nicole	Tobin

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		I- For State Registrar	Reg. No.							1 1								
Physicia edical Examir	n/	 Decedent's Name 	Decedent's Name (First, Middle,Last) Natasha Nicole Tobin								Date of De Month October	Day	Year 10		3. Jine of Death -2356 hrs			
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Funeral		5. Social Security N	lumber	6. Sex		7. Age (In yrs. last	birthday)	If Und	er 1 Year	If Under	24Hrs.	8. Date of B	irth(MM/	(DD/YYYY)	9. Birth	hplace (State or	
Director		215.15.	5453	1 M	2 V F	25		Yrs	Month	ns Days	Hours	Min.	09.26	5.19	985	Foreigr Cou	untry)MD	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Fun	3 Widowed			1 Yes Yes, Give Ye		No	1	Yes 2	No	specify:				spBil.a	.ck		
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Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	3 Suicide	6 Co	uld not be ermined	28e. Pla			ne, farm, stre		y, office bu	uilding, etc		28f. Location or Town, 70 South a	State)			ral Route Number, oura. MD	City
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S Regis	tate trar		OCT 1	5.20		1	044	1	La se		_							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 32375 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct. Elijah 9, Thomas, 2010 2:26 Medical Jr 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Months Hours Min. Dec. 7, 1952 Director 57 Alabama Yrs. 417-80-8201 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Bowie 1 X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 13508 Youngwood Turn 20715 U.S.A. items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 X Never Married 2 Married Black, White, etc. 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Wldowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finance Dept. of Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elijah Thomas, Sr. Willie Mae Kirt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Nunn (Sister) 3207 Woodley Rd., Montgomery, AL 36116 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) Rehobeth Cemetery 10-16-10 Dalassee, AL 21. Signature of Funeral Service Lice 22 Name and Address of Facility Bell Funeral Home Þ m 228 Tuskenna St., Haynesville, AL 36040 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Poliomyeliks disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 2 No Yes signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Kypho scoliosis 1 ☐ Yes 2 📉No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No .24 hours after deatn. e Funeral Director: After this certificate haleted filled in by the funeral director, pag 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**No 1 Yes Other: ျ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D46052 10/09/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anhway, anna polos, tup

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Hugh	Marion	Vineyard
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		1- For State Registrar			Ce	ertificate o	f Death				Reg. No	U	! U	32310	
Physic		1. Decedent's Nam								2. Date of D	eath			3. Time of Death	
Medical Exan	nine	Hugh Ma	rion V	ineyard						Month Octobe	Day r 8 , 20	Yea 10	ır	1246 hrs	
		4a. Facility Name (ion, give street and n	umber)		4b. City, Tow Severna				4	4c. County o			
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last bi				. last birthday)	If Under 1	Year	If Under 24H	rs. 8. Date of	thplace (State or				
Directo		215-94-8545 1XM 2_F			46 _{Yrs}	Months	Months Days Hours Min			04/10/ 2010			untry) MD		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmatic event, the Medical Examiner must be notified at once.	ြို	19a Informant's Na Harriett		, , , ,		19b. Mailing	Address (S	reet an Road	d Number or d Pasa	Rural Route N dena, 1	umber, C	City or Town	ı, State,	Zip Code)	
Baltimore, emit. Pages 1 and Department of Heal Important: If item		20a. Method of Dis 1 Burial 2		n 3 Removal fr	om State	Place of Dispos crematory or oth	er place)			Date	te 20c. Location - City or Town, State 3,2010 Glen Burnie, MD				
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Balt permit Depart Importinjury		21. Signature of Fu		e Licensee	22. N	ame and Add	ress of F	^{Facility} mb r	ose Fur	neral	1 Home	e of	Lansdowne		
Physician	-			complications that ca	aused the death	1271	9 Hamm	onds	s Ferr	v Road	Lang	sdowne	ь. M	D 21227 Approximate Interval	
/Medical	1	failure. List on	y one cause	on each line.							211 GSL, SI	ock, or riea	"	Between Onset and Death	
Examiner	1	Immediate Cause (or condition resulting		a. Compli			onic	<u>alcc</u>	ohol u	se				Death	
		Sequentially list cor	nditions	b.	,	,-									
	ner	if any, leading to im-	mediate	Due to (or as a	consequence of	of):					_				
	Examiner	(Disease or injury the	nat initiated	c. Due to (or as a	consequence o	of).									
uted nd ransit		d.													
760, ficate be executed g physician and street transit	n/Medical						09,11/30/2010.WS 7, per Fh/ME G909 11/5/10 TT								
'60, ate bo	₩ W	IF FEMALE:	nancy	, per Fn/ME G909 11/5/					d. Date of d	delivery					
	an/	23b. Was decedent past 12 months		I Live bi			al death	3E	ctopic pregna	ancy		Month	Da	ay Year	
P.O. Box 68760, that the death certificate b ned by the attending physic detached for use as the bun	Physicia	1 Yes 2 No 9 Unknown 9 Unknown					er (Specify)								
D. Ell the d by the diched	Phy	Part II. Other signif	esulting in the ur	iderlying caus	e given	in Part I	23e. Did tobacco use contribute to the cause of				ne cause of death?				
- % 20 S	Completed by					,,	J. 1						ably 4 🗹 Unknown		
ords, w requir us been s should I	ete									24a. Wa				ppsy findings available	
e law e has l	μ									perf	opsy form <u>ed</u> ?	de	ior to cor eath?	mpletion of cause of	
tal Rectian: The certificate		25. Was case refern	ad to madina				00.00				2N	0 1	✓ Yes	2 No	
Vital ysician: his certif director,	Be	examiner?		Hospital:	patient 2	ER/Outpatient		Othe	eath (Check	only one) ng Home 5	7 00000	0 0	011		
n of Vi ding Physi After this funeral dir	입	1 ✓ Yes 2 27, Manner of Death	No No	28a. Date of (Month,		28b. Time of Inj		niury at \	, Transii	28d. Describe				scene	
Division of Vital Records, tal or Attending Physician: The law requins after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:	1 Natural	5 Pend		Day,Year)		· I –		2 No			ary occurred	•		
/iSicrate der der irecto	<u>ig</u>	2 Accident 3 Suicide		stigation 28e. Place	of Injury - At he	ome, farm, street	factory, offic	e buildin	ng, etc.	28f. Location (Street and Number or Rural Route Number, City					
Divital o	er.	Suicide 4 Homicide		d not be (Specify)			-			or Town,				.,	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,	Medical C	29a. Certifier (Check only one) 2	Certifying Ph Medical Exar	nysician: To the best miner:On the basis o	f examination a	ge, death occurre	ed at the time, in, in my opini	date an	nd place, and th occurred a	due to the cau	ise(s) and	d manner a	s stated	cause(s)	
5 signal	Me	29b. Signature and t		and manner sta	ated.		29c. Lice							h, Day, Year)	
		1	4				0.0	C.M.E.			1	ober 9, 2		/	
	ŀ	30. Name and addre	ss of person	who completed cause	of death (Item	23a)						.,,			
		Donna M. Vi			edical Exan	niner 111 l	Penn Stree	et, Bal	ltimore, M	D 21201					
		31. Date filed (Month	1 5 20°	10 (32. Reg	jistrar's Signatu	farks									
Regis	161	UUI	TO 70	IU CHARDEN	- h.	1									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 32377 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate	of Death	Reg.	No.			
Physic Medical Exam		Decedent's Name (First, Middle,Last)			ay Year	3. Time of Death		
viedicai Exam	mer	Dennis R. Waddell Jr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	2010 4c. County of Death	0207 hrs			
		1600 blk N. Warwick Avenue	Baltimore		N/A			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth						
Director		220-90-6046 1XM 2 F 33 Y	rs. Months Days Hours Mir	11/23/	/1976 Foreign	intry) MD		
a		Usual Residence of Decedent						
ow any		10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits 1 X Yes 2 No		
Maryland 28a-f show d at once.	ţċ	MD N/A	Baltimore	1100	Citizen of What Coun			
ith the Maryland 23a or 28a-f sho notified at once.	Director	4300 Miami place		109.		uyr		
5 72 hours after death with the Maryland "matural", or items 23a or 28a-f she sal Examiner must be notified at once			21207 Vas Decedent of Hispanic Origin? (S	pecify Yes or No-	U.S.A.	an Indian, Black,		
death r item	Funeral		Yes, specify Cuban, Mexican, Puerto		White, etc.	,		
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		Specify: Bla	ck		
hours 'natur Exam	pe	during	ent's Usual Occupation (Give kind of most of working life. DO NOT use ret		6b. Kind of Business/Ir	ndustry		
36 nin 72 e. than '	ple	Elementary/Secondary (0-12) College (1-4 or 5+)	۸		NI / 3			
5-00 ed with tygien other he Ms	Completed	17. Father's Name (First, Middle, Last)		First, Middle, Mai	N/A den Surname)			
21215-0036 wild be filed within 72 hours afte Mental Hygiene. marked other than "natural", e event, the Medical Examiner	Be	Dennis Waddell Sr.	Kar	en Hughe	es			
MD 21215-0036 td 2 should be filed within 7 than and Mental Hygiene. In 27 is marked other than sumatic event, the Medica	٢		ng Address (Street and Number or i					
, ME und 2 s salth a em 27			00 Miami Place					
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		1 Burial 2 Cremation 3 Removal from State	Then Brown F/H	Date 2		Own, State		
Itim it. Pa rtmen ortant		4 Donation 5 Other Specify: AND Cre 21. Signature of Funeral Service Licensee 22.	ematory 10/	14/10	Baltimor	e,MD		
Ba Depa Imp Imp inju		District Al William 2	Oseph H. Brown 140 N. Fulton	ı Jr. Fu Ave. Ba	neral Hou	me PA		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and		
Examiner		Immediate Cause (Final disease a. Multiple Gunshot Wounds				Death		
r ^A		or condition resulting in death) Due to (or as a consequence of):						
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-			
-	mine	cause. Enter Underlying Cause (Disease or injury that initiated						
d d ansit	Exa	events resulting in death) Last Due to (or as a consequence of): d.						
760, frate be executed physician and the burial - transit	Medical	UNPENDED AMENDED						
760, cate be physic he bur	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery			
Sox 687 leath certifi e attending for use as t	sician/	past 12 months	etal death 3 Ectopic pregna	incy	Month Da	y Year		
Box 687 e death certifi the attending	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)					
P.O.	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the			
S, P.C uires that n signed d be deta	ed by				2 ✓ No 3 Proba			
Records, The law require ficate has been si	Completed			24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of		
Rec The la	E			performed Yes 2	d? death? ☐No 1 ✓ Yes	2 No		
cian:	Be	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FB/Outnation	26.Place of Death (Check					
fVi Physi er this	ဥ	1 Yes 2 No ruspital 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of		g Home 5 Res 28d. Describe how	inius occurred	Scene		
Division of Vital talor Attending Physician rs after death. at Director: After this certical in by the funeral director.	Ö	1 Natural 5 Pending Oct 10, 2010 0142 hrs		Subject shot	injury occurred			
/iSic r Atte ter dea irecto	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office building, etc.		et and Number or Rura	I Route Number, City		
Dital o	Certification:	4 V Homicide determined (Specify) Vacant Lot		or Town, State 1600 blk N. Warv) vick Avenue, Baltim	ore, MD		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation)						
To th within To th	Medical	and manner stated.						
		29b. Signature and title of certifier	29c. License number O.C.M.E.		od. Date signed (Mont)	n, ∪ay, rear)		
11		30. Name and address of person who completed cause of death (Item 23a)	J. U.IVI. L.	October 10, 2010				
1,			nn Street, Baltimore, MD 21	201				
	ate	31. Date filed (Month Car Year) 5 2010 32. Redistrar's Signature			 			
Regist	rar	ULI IU ZUIU Clevera 3.	and					

10-07846	
Kristie Walters	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kristie Walters		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 32378										
Physici Medical Exam		Decedent's Name (First, Middle,Last) Kristie Walt	ers	2. Date of Death	3. Time of Death							
		4a. Facility Name (if not institution, give street and number) 1611 Inverness Avenue	b. City, Town, or Location of Dundalk	f Death	4c. County of Death Baltimore County							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Unde	r 24Hrs. 8. Date of Birth (N	MM/DD/YYYY) 9. Birthplace (State or							
Director		213-11-6412 1_M 2\(\overline{\text{X}}\)F 40 Yrs	Months Days Hours	Min. October 2,	, 1970 Country) Maryland							
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City Limits							
	5	Maryland Baltimore	Dundalk		1 Yes 2 X No							
Maryla • 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?							
5-0036 led within 72 hours after death with the Maryland dygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.			21222		USA							
leath w r items	Funeral		s Decedent of Hispanic Origi es, specify Cuban, Mexican,		Race - American Indian, Black, White, etc.							
after c	by F	3 Widowed 4 X Divorced If Yes, Give Year 1 1	Yes 2 X No specify:		Specify: White							
2 hours "natu			's Usual Occupation (Give k ost of working life. DO NOT u		b. Kind of Business/Industry							
15-0036 filed within 72 Hygiene. d other than	Completed		retary		Insurance Company							
21215-003 uld be filed withi Mental Hygiene marked other ti t event, the Med	-	17. Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, Maid								
D 2121 should be fil and Mental I 7 is marked	To Be	Roger Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Numb	ta Chaney Der or Rural Route Number	, City or Town, State, Zip Code)							
MD d 2 sho lth and n 27 is aumati	_	Roger Walters Father 216 Sa	lk,Maryland 21222									
or Heal		20a. Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State	tion (Name of cemetery, er place)	October 20	Oc. Location - City or Town, State							
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: Bayview C	rematory	16,2010	Baltimore, Maryland							
Ba permi Depa Impo injur		Control on the control of the contro	ame and Address of Facility nelly Funera 10 Sollers Po	l Home of Du	ndalk,P.A. ndalk,MD. 21222							
Physician		23a. Part I. Enter the disease or complications that caused the death. To not enter the failure. List only one cause on each line.	e mode of dying, such as car	rdiac or respiratory arrest, s	shock, or heart Approximate Interval Between Onset and							
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	on		Death							
		Sequentially list conditions. b										
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
Si sa	Examiner	events resulting in death) Last Due to (or as a consequence of):										
0, be executed sician and	dical	d. X UNPENDED ☐ AMENDED 23a,pt.II,27,	28a-f per me	0911 1-24-11	l vt							
760, cate be ex physician he burial		IF FEMALE: 23c. If yes, outcome of pregnancy	nod i poi me		23d. Date of delivery							
Box 6876(death certificate the attending physical for use as the b	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fett 4 Pregnant at time of death 5 Oth	Month Day Year									
Box e death the atte	Physician/Me	1 Yes 2 No 9 V Unknown 9 Unknown	er (Specify)									
- E > E	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part		o use contribute to the cause of death? No 3 Probably 4 V Unknown							
ords, I	ed	Bipolar Disorder	24b. Were autopsy findings available									
Recor The law r icate has b	Completed			24a. Was an autopsy performed	prior to completion of cause of death?							
Division of Vital Records, P.O Ital or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed be led in by the funeral director, page 2 should be detail	o l	25. Was case referred to medical	26. Place of Death (C		No 1 Yes 2 No							
Vital Physician: this certifi	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other	Nursing Home 5 Resid	dence 6 🗸 Other: Scene							
n of \int of \int of high high high high high high high hig		27. Manner of Death 1 Natural 5 Pending 28a Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	1 Ves 2 🔻 A	28d. Describe how in	njury occurred							
ivisior or Attencafter death Director:	ertification:	2 Accident Investigation 10-12-10 fd 5:45	pm	unknown	t and Number or Rural Route Number, City							
Divi	Certi	4 Homicide determined (Specify) house		or Town, State)	erness Ave. Dundalk, Md							
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Winder Examiner: On the basis of examination and/or investigation		e, and due to the cause(s) a	and manner as stated.							
To the with Comp	Medi	and manner stated. 29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)							
		auetz.	O.C.M.E.		ctober 13, 2010							
Ø.	-	30. Name and address of person who completed cause of death (Item 23a)	1									
V		21 Poto filed (Manth Den Voor) 22 Pototy Signature	eet, Baltimore, MD 2	1201								
Sta Regist		31. Date filed (Month Denniera) 5 2010 32. Refistrar's Signature	eld									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2228 Lorraine Joann Young Medical 4a. Facility Name (if not institution, give street and numb Examiner City, Town, or Location of Death 4c. County of Death Stimore 5. Social Security Number (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Hours Min 0671871954 218-60-4766 Director 56 Maryland Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh be notified a 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b Division Street apt.1A 1801 21217 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unemployed N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Joseph Young Harriett Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Webb(son) 1605 Balmor Ct. .Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 Carcemation 3 ☐ Removal from State And Crematory or other And Crematory 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses hddra of Fallyown Jr. N. Fulton Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death -Physician/ disease or condition resulting in death) edical Examiner Farlure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ October 2010 а м Robert Carson ASHBY 5:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Williamsport Nursing Home <u>Williamsport</u> <u>Washington</u> 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours Min (Month, Day, Y Feb. 24 Maryland Director 218-24-9298 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 23a or 10f. Zip Code 10g, Citizen of What Country? Funeral 618 Chestnut Street 21740 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed Year or Dates. 1948-50 White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Freight Delivery other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Ashby Elston Ida Whitacre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquelyn M. Ashby - Wife Chestnut Street, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury Cedar Lawn Mem. Park :10/6/10 Hagerstown, Maryland 21. Signature of Suneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 16 level B any 21740 <u>415 E. Wilson Blvd.</u> Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ASPIRATION PNEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NSPHAGIA MONTHS Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ALZHEIMER DEMENTIA attending physician and for use as the burial-transit STAGE Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 2 🗌 No 9 Unknown 9 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, æ 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? death 2 🗆 No Accident Investigation within 24 hours after deati To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year,

State Registrar

WH-5+1

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

HOWE

31. Date filed (Month, Day, Year)

OCT 0 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT. 2010 DAVID CLIFFORD AUSTIN JR. 5:30 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3308 CHISWICK CT. MONTGOMERY SILVER SPRING 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth
JAN 8, 1913 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours OHIO 291-07-6810 97 Yrs Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 🗆 Yes 2 😾 No MONTGOMERY SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3308 CHISWICK CT 20906 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOV'T. EXECUTIVE FED. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVID CLIFFORD AUSTIN BESSIE MAY HATTERSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLYNE W. AUSTIN/WIFE 3308 CHISWICK CT., SILVER SPRING, MD. 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 9-28-2010 RIVERDALE, MD. 21. Signature of Funeral Service Licenses CHAMBERS OF FUNERAL HOME & CREMATORIUM, P.A ambura M00091 5801 CLEVELAND AVE., RIVERDALE, MD.

Ph_sician/ Medical Examiner

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show be notified at

er than "natural", or items 23a of the Medical Examiner must be

permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once.

72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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tending physician and ir use as the burial-transit detached signed by

should be within 24 hours after death.
To the Funeral Director: After completed filled in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

101

29b. Signature and title of certifie

Advi

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hurley

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Y	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the dear cause on each line. ATRIAL FIBSE Due to (or as a conseq	RILLATION	le of dying, such as cardiad	c or respiratory arrest,		Approximate Interval Between Onset and Death 7 YRS.
Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events c.	Due to (or as a conseq					
edical E	resulting in death) Last	Due to (or as a conseq	juence of):				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 D Ectopic	pregnancy pecify)		23d. Date of de Month	olivery Day Year
ompleted by PI	Part II. Other significant conditions cont			cause given in Part I.			o the cause of death?
اد	SQUAMOUS CELL CAI	RCINOMA			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
pe	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
0	1 ☐ Yes 2 🔀 No	spital:	ER/Outpatient 3 D	OA Other: 4 D Nursing F	lome 5 🗓 Residence	6 ☐ Other (Spec	eifv)
псате:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of 2 injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
al Certi	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factor	r, office	28f. Location (Street a City or Town, Star	and Number or Ru te)	ral Route Number,
Medic	(Check 2 L Medical Examine)	ian: To the best of my know r: On the basis of examination Practioner: To the best of my	n and/or investigation, in	my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated.

29c. License number

MD 9060658

29d. Date signed (Month, Day, Year)

28

CONNECTICUT AVE., KENSINGTON, MD. 20895

State Registrar

			For	Sta	ate of M	1arylan	d / Depa	artme	nt of H	lealth	and M	1ental Hy	giene)				
			= State RegistraMEND#2perM),10/12/	10,BMW,	MbCo	Cer	tifica	te of [Death			Reg. No	201		3238	2	
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)						_		Date of Dea Month	ath Da	24	Year	3. Time of Deat		
	Medic			Ruth J		6 Agr	an					Septemb	er-	25, 2	010	5:29 _k)м	
	Examin	er	4a. Facility Name (if not institution									40	f Death					
			Sunset Ridge 5. Social Security Number	. 0 √ F 7			et hirthday)	Frederick If Under 1 Year If Under 24 Hrs.			8. Date of Birt	h		0 Rietho	derick ace (State or Fore	ian		
	Funeral Director		096-09-4637		Sex 7. Age (In yrs. last bir			Months Days			Min.	(Month, Day	y, Year)	17	Count	New Yor	b	
			Usual Residence of Decedent					1 1 1 10/					/ [/]	New 70%	IC_			
	land sho	tor	10a. State 10b. County			10c. City	y, Town or Lo	cation					d. Inside City Lin					
	Mary 28a-1 otifie	Director	Maryland				olumb	bia_					1 🗌 Yes 2 🗶	No				
	h the	al D	10e. Street and Number					10f. Z	ip Code			10g. Citizen of What Country?						
	ms 2; must	Funeral	9513 Deer			F:- 11.6		1/1- D		210		- '6 - \/ \\						
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Mar	Arı	as Decedent med Forces' Yes 2 D	?	5. 13. V	f Yes, sp	ecify Cuba	n, Mexica						Race - American Indian, Black, White, etc.		
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Ō	hour natur lical	Completed		nt's Education			16a. Deced	lent's Us	ual Occup	ation	. 4		16b. K	(ind of Bus	iness Ind			
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and	e filer ntal H ed ot ed ot																	
Maryland 21215-0036	d Mel d Mel mark matic																	
<u>≅</u>	Stephen Josloff - Son 8378 Inspiration Avenue, We																	
ē,	1 and f Hea item othe		20a. Method of Disposition				lace of Dispo	sition (Na	ame of			Date		ocation - C				
E O	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		val from Stat	e Kin	emetery, cren a Davi	natory or d Mo	other plac m G	ndns	09/2	7/2010	Fall	s Chi	vrch.	Virain	ia	
altimore,	permit. I Departir Importa any inju once.		4 Donation 5 Other (Specify) King David Mem. Grdns 09/ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility His 11800 New Hampshir								lity Hin	es-Rina	ldi	Fune	ral i	Home, In	c.	
m			MINEMO	me	Vark	n	11	800	New 1	Hamps	shire	Ave.,	Sili	ver S	prin	g, MD 20	904	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of				h. Do not ente	er the mo	de of dyin	g, such as	s cardiac c	r respiratory arr	rest,			Approximate Interval Between		
	Physician/		Immediate Cause (Final disease or condition	2	Ren	al Fa	ilure									Onset and Death		
	Medical Examiner		resulting in death)	~ "-	Due to (or as													
		er	Sequentially list conditions, if any leading to in mediate.										-					
	dig eq	Examiner	if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury		,		Atrial	Fib	HiPPI	tion	1							
	xecut n and al-trar	Exa	that initiated events resulting in death) Last	esulting in death) Last Due to (or as a consequence)						20001	<u>ν</u>				1	<u> </u>		
09	death certificate be executed re attending physician and ed for use as the burial transit	dical		d	S/P Myocardial Infarction													
_	ificate I ig phys as the	Med	IF FEMALE:															
Box 68	r use	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy										23d. Date of del			,		
80		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		□ Pregnant□ Unknown		death 5	Other (specify)					Mont	th	Day Year		
P.O.	The law requires that the death certificare has been signed by the attending page 2 should be detached for use as I		Part II. Other significant condition	ons contribut	ing to death	but not res	ulting in the u	nderlying	cause giv	en in Par	t l.	23e. Did to	obacco	use contrib	oute to the	e cause of death?		
ď.	res th signe	Completed by	Thoracic A	orta A	neuru	Sm						1 🗓	Yes 2	□ No 3	B 🗌 Prob	ably 4 🗌 Unkn	own	
ğ	requi been shoulk	lete	History of		•							24a. Was a	an .	24b. We	ere autop	sy findings availa	ble	
ec	e has	duc	masaury of	venier	mu_							autop perfo	osy rmed?	pri de	ior to con a th ?	npletion of cause	of	
<u>~</u>	sician: The law certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical						26. Pl	ace of De	ath (Check	1 Yes	2 X N	0 11	Yes	2 LJ No		
Division of Vital Records,	ysicie is cert direct	To B	examiner? 1 ☐ Yes 2 💆 No	Hospita	al: 1 🗆 Inpa	tient 2 🗆	ER/Outpatier	nt 3 🗆 I	DOA Othe	er: 4 🗆 N	Jursing Ho	me 5 Resid	dence 6	6 🗶 Other	(Specify)	Living	đ	
ō	ng Ph ter th		27. Manner of Death 1		a. Date of inj (Month, D		28b. Time of injury		28c. Injury work	y at	- 1	28d. Describe h	ow injur	y occurred	l			
on	eath. or: Af the fu	ifica	2 Accident Investig	gation not be				М	1 🗆	Yes 2								
NSIN N	or Att	Certificate:	4 Homicide determ			ijury - At ho tc. <i>(Specify</i>	me, farm, stre	eet, facto	ory, office			28f. Location (S City or Tow			or Rural	Route Number,		
Ō	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,		29a. Certifier 1 X Certifying	Physician	To the best o	of my knowl	edge death	occured a	at the time	date and	place an	d due to the car	use(s) as	nd manner	as state	1.		
	e Hos 124 h e Fun	Medical		xaminer: On	the basis of	examination	and/or invest	tigation, i	n my opinic	on, death o	occurred at	the time, date a	nd place	e, and due t	o the cau	se(s) and manner s	itated.	
	To the withing to the comp	2	29b. Signature and title of certifier						c. License		F			te signed (
	10		1 Fet	le	ترب	7	ND			D05	7647		S	eptem	ber	25, 2010		
	1-		30. Name and address of person															
			Ernest Clevinge	r, MD					Driv	e, F	reder	ick, Ma	ryl	and 2	1702			
	Stat		31. Date filed (Month, Day, Year)	40	82. Regist	rar's Signat	har.	W.										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CURTIS AUSTIN SEPTEMBER 29 2010 9:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Min. Days Hours (Month, Day, Year APRIL 1 1 WEST VIRGINIA **Director** 236-30-2607 84 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 □ No WV KANAWHA CHARLESTON 10e. Street and Number ō 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 1209 GRANT STREET 25302 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ò þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 4 MUSICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **JAMES** AUSTIN LOTTIE L. BOWLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 BENSON LANE FORESTVILLE, MARYLAND RUTH AUSTIN PARKER/SISTER 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, SPRING HILL CEMETERY 10/9/2010 CHARLESTON, WEST VIRGINIA ☐ Donation 5 ☐ Other (Specify) J. B.JENKINS FUNERAL HOME, INC. Signatu of Fundamental Service L 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) FATAL CARDIAC ARRHYTHMIA Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for sela concedurance of Examir HYPERTENSIVE CARDIOVASCALAR DISEASE been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical OLD STROKE Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Month Year Pregnant at time of death 1 Li Yes 2 L 9 Li Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? this certificate Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 (XNo 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at s after death. Certificate: 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Registrar

DHMH 17 Rev 7/2009

only one) 29b. Signature and title of certifier

Date filed (Month, Day)

OCT 0 4

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

OPHNELL CUMBERBATCH M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Burch Physician/ Mari October Theresa 3° 2010° 2:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 29431 Charlotte Hall Road Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 Months Hours Sept. 28, 1943 Washington, DC **Director** 213-42-5349 67 Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits St. Mary's 1 Yes 2 X No Maryland Charlotte Hall 10e. Street and Number 10g. Citizen of What Country? Funeral 29431 Charlotte Hall Rd. Apt. 15 20622 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examination Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence V. Burch, Jr. Rose P. Lauriloa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Frances R. O'Neill/Sister 40325 Waterview Dr., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Oct. 9, Ponation 5 Other (Specify) Brinsfield-Echols Crem 2010 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signatur of Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Small cell lung cancer - extensive St. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 4 months Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Due to (or as a gensequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year signed by the a d be detached for 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed' 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-5-10 00068120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manoj Shah, 23415 Three Notch Rd., California, MD 20619 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0 8 2010 Registrar

DHMH 17 Rev 7/2009

10-07605 Michael Wayne	Buc		Print in Black Indelible f Maryland / Department			ble.	0 3238		
		1- For State Registrar	Certificate		Reg.		0 3236		
Physici		Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death		
Medical Exami	ner	Michael Wayne Bu			Month October 3, 2		1712 hrs		
		4a. Facility Name (if not institution, give 29765 Three Notch Road	street and number)	4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St. Mary's			
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Birt	hplace (State or		
Director		218-90-9081	76	Months Days Hours Min.	Jan. 29	Foreig			
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits		
<u>≩</u>	Ļ	Maryland St. Mary	's Charlo	tte Hall			1 Yes 2 X No		
laryla: 28a-f:	ecto	10e. Street and Number		10f, Zip Code	10g.	Citizen of What Cour	try?		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	29765 Three Notch	Rd.	20622		United St	ates		
h with	Funeral			Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	can Indian, Black,		
r deat or ite	Fun	1 X Never Married 2 Married	1 Yes 2 X No	- X -	(todii, oto.)	Whit	е		
rs afte rral", miner	by	Widowed 4 Divorced 15. Decedent's Education (Specify only)	Yes, Give Year 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No specify: ent's Usual Occupation (Give kind of w	adi dana Ido	Specify:			
2 hour	ted	Elementary/Secondary (0-12)		most of working life. DO NOT use retir		b. Kind of Business/Ir	idustry		
336 thin 7 re.	Completed	10	Cler	·k		Grocery			
215-0036 be filed within 7 total Hygiene. rked other than ent, the Medica	Con	17. Father's Name (First, Middle, Last)	0202	18.Mother's Name					
21 be fil irked	Be	Michael Buckler		Joyce H					
D 21 should I nd Mes is man	٩	19a. Informant's Name/Relationship (Typ	, City or Town, State,						
, MD and 2 sho salth and em 27 is		Joyce Buckler/Mot		82 Dukesville Dri					
Ore, jes 1 a of He			Removal from State Trinity		Oct. 9,	Oc. Location - City or			
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other Specify:				Waldorf, M			
Bal permi Depar Impo		21. Signature of Funeral Service License	11/	Name and Address of Facility Bri 195 Three Notch R			The state of the s		
Physician		23a. Fart & Enfer the disease, or complic	ations that caused the death. Do not enter				Approximate Interval		
//Medical	xaminer	failure. List only one cause on each Immediate Cause (Final disease a.	line. Cocaine Intoxicati				Between Onset and Death		
Examiner			e to (or as a consequence of):	OII					
		Sequentially list conditions, b							
		if any, leading to immediate Due to (or as a consequence of):							
=	хап	(Disease or injury that initiated —	e to (or as a consequence of):						
ecuted and transit	a E	d	22. 27.20		0.10				
), be existian urrial -	dic	X UNPENDED	AMENDED 23a,2/,28a-1	per me g908 10-1	9-10 Vt				
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregnan		23d. Date of delivery	V		
x 68 h certi tendin use a	cial	past 12 months?	Pregnant at time of death	etal death 3Ectopic pregnan Other <i>(Specify)</i>	cy	Month Da	y Year		
Boy te death the att	hysi	1 Yes 2 No 9 Unknown	9 Unknown						
s, P.O. B. ires that the de isigned by the	by P	Part II. Other significant conditions conditions	ontributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the			
S, P					1 Yes 2	No 3 Proba	bly 4 🗹 Unknown		
cords law requi	Completed				24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of		
Che la	E				performed 1 Y Yes 2		2 No		
tal Records cian: The law requi certificate has been	B B	25. Was case referred to medical examiner?		26.Place of Death (Check or	nly one)		Invested		
Vit	리	1 ✓ Yes 2 No	pital: 1 Inpatient 2 ER/Outpatier		Home 5 Res	idence 6 🗸 Other.	Scene		
n of ding F	Ë	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year) 28b. Time of		28d. Describe how	injury occurred			
SiOl Attend death death cctor:	cati	2 Accident S Pending Investigation	fd 10-3-10 fd 5:0		ınknown				
Division of Vital Records, P.O. Soptial or Attending Physician: The law requires that the hours after death. Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At home, farm, stre	eet, ractory, office building, etc.	or Town, State)	29765 Thi	Route Number, City Ree Notch R		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a Certifier	house To the best of my knowledge, death occur	urred at the time, date and since and since		e Hall, Mo			
thin 2.	Medical	one) 2 Medical Examiner: 0	n the basis of examination and/or investiga						
To To	Me	29b. Signature and title of certifier	d manner stated.	29c. License number	29	d. Date signed (Mont	h, Day, Year)		

Famely Marketty MI)
30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

State 31. Date filed (Month, Day, Year) Registrar

October 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State	of Maryla	nd / Depa	artment <i>rtificate</i>			nd M	_	giene)	32386	
			Decedent's Name (First, Mide	dle, Last)							2. Date of De	ath			3. Time of Death	
	Physic		Anne.	Bankı	ntes						Month 0 9	Day	20		16:05 M	
	/Medi Examir		4a. Facility Name (If not instituti	on, give street and n	ve street and number) 4b. City, Town, or I				ocation of	Death		4c.	4c. County of Death			
1			University &	pecealip	seciality Hospital			Baltimore				None				
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Bir	th Veer)	9. 1	Birthpla Countr	ce (State or Foreign	
	Director		130 38 2652	1 M 2 F	93	3 Yrs.	MOHUIS	Days	Tiours	141111.	8. Date of Bir (Month, Da 10-19-	1916		Country	NY NY	
	pun *		Usual Residence of Decedent 10a. State 10b. Count	hv.	100.0	City, Town or Le	ocation							100	d. Inside City Limits	
	the Marylan r 28e-f show notified at	5												100	1 ☐ Yes 2 🎇No	
	28e-1	Director	MD Howa 10e. Street and Number	ra	Ellicott City							10a Citi	zen of What	Counts		
	with a or	급	8963 Furrow Av		21042						ited S		•			
	ours after death wit ral', or Items 23a c	Funeral	11. Marital Status		cedent Ever in	U.S. 13			nanic Orig	in? (Spe	cify Yes or No			n Indian,		
10	fter d	Fun	1 Never Married 2 Ma	Armed F			If Yes, specify	y Cuban,	Mexican,	Puerto F	Rican, etc.)	c.				
036	hours a	þ	3 ₩ Widowed 4 □ Divorce	If Yes G	live Dates:	1 ☐ Yes 2 ☑ No Specify:							Specify: V	√hit	æ	
0-10	within 72 hours after death with the Maryland one. than "natural", or Items 23e or 28e-1 show the Medical Examator must be conflied at	Completed	15. Decede	ent's Education	B	16a. Dece	dent's Usual	Occupati	on ring most	of working		16b. Kii	nd of Busine			
21:	thin 7	nple	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)	life.	DO NOT use	retired)	nny most	OI WOIKII	19					
2		Con		4		Soci	lal Woı	cker				P	rivate	e C1	inic	
nd	d la b	Be	17. Father's Name (First, Middle								(First, Middle					
<u>×</u>	should be tind Mental I	၉	George Angelak			-		1	-		havas					
Maryland 21215-0036	C 0 0 0		19a. Informant's Name/Relation								Route Numb					
	of Health item 27 other tr		Paul G. Baniki	otes/Son	Furrov osition (Name		enue		cott C		, MD 21042 Location - City or Town, State					
0	Pages 1		20a. Method of Disposition 1 Burial 2 Cremation	a 3 XIRemoval from	State	cemetery, cre	matory or oth	er place)	1 .							
ţ	t. Pa tmen tant;		`4 □Donation 5 □ Other		M	It. Hope		-	1						ludson, NY	
Baltimore,	permit. Pages Department of I Important; If its any Injury or o		21. Signature of Funeral Service	hi - W	M01	044 2	2. Name and .12 Olc	Address Co	of Facility Lumbi	Harr a Pi	y H. W ke Ell	itzk icot	e's Fa t City	amil	y FH Inc. ID 21043	
п			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that st only one cause on	caused the de	ath. Do not en	ter the mode	of dying,	such as c	ardiac o	r respiratory a	rrest,			Approximate nterval Between	
	Physician		Immediate Cause (Final disease or condition	5	ebsis									g	Onset and Death	
	/Medical		resulting in death)	-	(o as a conse	equence of):	,								7.3	
A	Examiner	L	Sequentially list conditions,	b	inges	tive	hear	t	Faul	Rur	•			2	t days	
	sit ad	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or es a conse	equence of):		- (U							
	be executed ician and burial-transit	Exami	that initiated events resulting in death) Last	c. Due to	o (or as a conse	advence of).								_		
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687	phys phys s the	dlcal		d												
	leath certifica attending ph I for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of preg	nancy							23d. Date of	deliven	,	
Вох	death e atten	clar	in the past 12 months?		birth 2 Fe		∃Ectopic preg ∃ Other <i>(spec</i>						Month		ay Year	
0	that the de ed by the detached	ysi	1 □ Yes 2 ⊡ No 9 □ Unknown	9□ Unk				,,								
۵.	requires that the een signed by th nould be detache	y Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did t	obacco u	se contribute	e to the	cause of death?		
rds	w requires that been signed to should be deta	q p		entia							1 🗇 '	Yes 2	3 No 3□	Probab	oly 4 🗆 Unknown	
of Vital Records,	> 0 10	ompleted	Decu	Situs U	Cor						24a. Was	an	24b. Were	autops	sy findings available	
Be	0 = 0	шс										rmed?	prior death	to comp	oletion of cause of	
ta	Ician: Th certificate rector, pag	O .	25. Was case referred to medic	al					of Place	of Death	1 Tes		1 📙 1	es 2	□ N0	
>		To B	examiner? 1 ☐ Yes 2 ☑ No	Hacnital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA	Othor			ne 5 ☐ Resi		S ∏Other (S	ipecify)	100	
			27. Manger of Death	28a. Date	of Injury nth, Day Year)			: Injury a Work?			8d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
0	Attending F r death. ector: After by the funera	atlo	1 Natural 5 ☐ Pend 2 ☐ Accident inves	tigation (Mis	Albert	Injury	М		s 2 🗆 N	lo	NIA					
Division	er de recto by th	tiffic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	d a a t b a		home, farm, st	reet, factory,	office		2	8f. Location (Rural I	Poute Number,	
O	spitel or Atten ours after deat neral Director; filled in by the	Certification:			Jang, Sto. (Opon	NIN					NIA	m, olalo,				
	Ho Fur eely	edical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the Examiner: On the and ma	e best of my k basis of exami nner stated.	nowledge, deat nation and/or in	h occurred at vestigation, in	the time, my opin	, date and nion, death	piace, a	nd due to the id at the time,	cause(s) date and	and manner place, and	as stat	ed. he cause(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certif	ier			29c. I	License n	number			29d, Date	e signed (Mo	onth, Da	ay, Year)	
,			1 Tous	hanne	7			00	50	48	U	09	128	11	0	
6			30. Name and address of perso	n who completed car	use of death (It	em 23a) (Type.	_							1 1	_	
t			30. Name and address of person SERLU ZERA-Y 31. Date filed (Month, Day, Yea, SEP (PHANNES	6015	· Charl	er St	rest	t, B	Bal	timo	/-e	MD	21	236	
	Sta	te	31. Date filed (Month, Day, Yea	32.	Registrar's Sig	nature	1		1							
	Regist	ar	SEH S	3 0 2010	ensus	B. 1	parker									

Banikiotes, Anne

100 Rolling Road, Gaithersburg, MD 20877 20c. Location - City or Town, State Rockville, MD 10 East Deer Park Drive Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical center Dr. Rockville, Maryland Mª Neil 20850 Patsy M. MD 31. Date filed (Month, Day, Year) State Registra DHMH 17 Rev 7/2009 **ORIGINAL**

3. Time of Death

9. Birthplace (State or Foreign Country) Tennessee

White

10d. Inside City Limits

1 X Yes 2 □ No

0114 AM

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert E. Branzell September 2010 2:45pm M Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 101 Odendhal Ave. #408 Montgomery Gaithersburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟፟M 2 □ F Days Hours 219-48-0196 64 Mar. 20, 1946 Virginia Yrs Director Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 101 Odendha1 Ave #408 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 Widowed 4 X Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Heating and Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Air Conditioning Technician permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any injury or other traumming once. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Branzell Jane Albery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha B. Green (Sister) 10904 Troy Road Rockville, MD 20852 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. 2010 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. e attending physician and ed for use as the burial-transit Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hepatitis C 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Alcohol Dependence this certificate 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury 1 Yes 2 No Director: / Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year September 28, 2010 D52481 - MO

Registrar

18111 Prince Philip Dr. #304

Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David H. Plotkin M.D.

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 025 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Mandrin House Harwood Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) North Carolina If Under 24 Hrs. 8. Date of Birth **Funeral** Date of Month, Day, Months Days Hours Min 1 D M 2 X F Director 239-32-0943 85/rs 1925 Apr. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Washington DC N/A 1 Yes 2 No 10f. Zip Code 20012 10e. Street and Number 10g. Citizen of What Country? Funeral 7536 Eastern Avenue, NW United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. **African** Completed by 1 Never Married 2 Married Yes 2xxNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Americam 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other transmitted. Elementary/Seconday (0-12) College (1-4 or 5+) Dietitian Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ం Arthur Barnes Gladys Woodard 19a. Informant's Name/Relationship (Type, Print)
Gladys P. Brawley / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1132 Abbey Place, NE, Washington DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 9/29/2010 Brentwood, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, 7400 Georgia Avenue, NW, Washington DC 20012 the 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE DEMENTI disease or condition ears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) MANDR/A 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes Accident 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🖂 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Ite

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 25, 2010 Year Millicent Jean Broadus 2:50 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Hours Min Nov. 16. 1930 Director 309-26-6807 79 TN Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It has a special and a special and Mental Hyglene with a special and a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3330 N. Leisure World Blvd., #526 †20906 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 **X**No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: **Black** Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ James S. A. Mitcham Mayme Austin 19a. Informant's Name/Relationship (Type, Print Jerome R. Broadus/Husband 19b. Mailing Address (Street and Number or Ryral Route Number City or Town, State, Zin Code) 3330 N. Leisure World Blvd., Apt. 526, Silver Spring, MD 20906 permit. Page 1 and 2 sl
Department of Health s
Important: If item 27 is
any injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎦 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sept. 2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Acute Myocardial Infarction immediate Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Atherosclerosis more than 10yr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial vansit that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Year Yes 2 No 9 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> End-Stage Renal Disease Completed 1 ☐ Yes 2 The No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ! 1 Yes 2 No Yes 21 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2x No မ 1 Inpatient 2 SER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of certifie 29b. Signaty 29d. Date signed (Month. Day, Year)

State

18109 Prince Philip Drive, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Henjum, MD

29 2010

31. Date filed (Month, Day, Year)

D35045

Sept. 25, 2010

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month JOSEPH AUGUSTUS BESSO, JR. SEPTEMBER 24, 2010 11:00 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 EAST CHESTNUT STREET TALBOT ST. MICHAELS 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 10/2/1942 67 Director MASSACHUSETTS 025-30-2008 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at Director 1XYes 2 No MD TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 EAST CHESTNUT STREET 21663 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Folces:

1 XYes 2 No
If Yes, Give 1960—
Year or Dates: 1963 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) GENERAL Elementary/Secondary (0-12) College (1-4or 5+) is marked other than **PHYSICIAN** 12 PRACTITIONER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH AUGUSTUS BESSO, SR. KATHERINE CECELIA BOLANDIS မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 NANCY E. BESSO, WIFE Health tem 27 i 904 CALVERT AVENUE, ST. MICHAELS, MD permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 9/28/2010 STEVENSVILLE, MD 4 Donation 5 ☐Other (Specify) 21. Sign FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601 art 1. Enter the discase, or complication shock, or heart failure. List only one call o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) that the death certificate be executed and Due to Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ or Attending Physician: The law requires 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA esidence 6 Other (Specify) After this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C To the Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in much 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 10+VA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1903 2010 Bridget Michelle Brown Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOR
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, O4 - 1 3 - 1)
 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Del Director 222-48-8918 38 1972 aware Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Talbot Easton 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 9669 B Cordova Road 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Dr. Mautz Dental Assistant Be BROWN, BRI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I tant: If item 27 is marked o Jimmy A. Brown, Sr Thelma J. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma J. Green/Mother 5146 Paw Paw Point Rd., Cambridge, Md. 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hills Cem. 10-02-10 Dover De 22. Name and Address of Facility Bennie Smith Funeral Home Signature of uneral Service Licensee Division St Dover, De. 19904 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death Pnysician Intracerebral hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Malignant Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No ☐ Yes To the Funeral Director: After this certific completed filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 9-24-2010 D54488 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID 21601 Jennett 219 C+VA baiked 31. Date filed (/ . Registrar's Signature 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ SEPTEMBER 29 2010 CANDIS 12:05P M BARR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔏 F Months (Month, Day, Director 249-72-7801 67 1943 SOUTH CAROLINA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be matified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director KENT 1 Yes 2 ☐ No DOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 166 J WILLIS ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Yes, 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK Completed 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH GRAHAM OSSIE HANNAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH BARR/DGT. 16135 EDENWOOD DRIVE BOWIE, MARYLAND 20716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10-5-2010 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MD NATIONAL CEMETERY Signature of Functor Service Li J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) nding physician and ise as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕱 No Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an nas autopsy performe After this certificate 2 🗆 No 2 No Yes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes ၉ 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

Certificate: n 24 hours after deam.
he Funeral Director: Af Medical 29a. Certifie (Check only one) State Registrar

of person who completed cause of death (Item 23a) (Type, Print)

2001 MO

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

016376

29d. Date signed (Month, Day, Year) 301

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G908, 10/15/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)

April Bozman 2. Date of Death Physician/ APRIL September 8:12 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Adelphi House Prince George's Adelphi If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Ma Worth, Day 1 941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 085-32-7687 69 Director New York Usual Residence of Decedent or 28a-f show a notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4506 Yucca Street 20705 United States 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White 3 Divorced Completed Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Reynolds Shirley Ann Hurlburt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D.B. Lewis -daughter 3104 Kimberly Road Hyattsville, Maryland 20782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 10/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancer Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed 2 No Yes 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted 2 1 No Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 X Other (Specify) Living 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 \(\subseteq \text{Yes} \) 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier

MSRAGORMAN O DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. Rajapakse, M.D. 2835 Smith Av. S-203- Baltimore, MD. 21209-

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

5 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 9:04 РМ Orlando Caciola October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Months Hours Min. (Month, Day, Year) July 1, 1915 Country) Pennsylvania Director 95 096-01-8113 Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Severna Park Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 43 West Mckinsey Road, Apt. 322 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White If Yes Give Completed 3 Wldowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry United States (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Officer Government nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Italia Arfoni Caciola James Vincent Caciola and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21108 145 Longfellow Drive, Millersvile, Maryland Chris Brown / Step Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State October 7, 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland Memoria1 Gardens 2010 . Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on past line. Approximate Interval Between Immediate Cause (Final ₽nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a Was an After this certificate has page 2 autopsy perform death? 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 Certificate: To 1 Sepatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical 29a. Certif certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Sign

State Registrar

OCT 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month eptember Physician/ 201 8.40 CHARLES WILLIAM CLICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 31, Virginia Director 230-62-4002 61 1949 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? 23a Funeral 3423 Kemptown Church Road 21770 U.S.A. items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. ō 1 Never Married 2 X Married δ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CPA Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank B. Click Evelyn Randolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Susan M. Click / Wife 3423 Kemptown Church Road, Monrovia, MD 21770 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Olivet Cemetery 10/1/2010 Frederick, Maryland 21. Signat of uneral Service Lice 22 Name and Address of Eacility & SON FUNERAL HOMES, P.A. NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Blood Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events Chalestero High and the burial-tran Due to (er as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Pregnant
Unknown Month Day Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Hospital or Attending Physician: The law requires 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N death? After this certificate To Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Tes 2 🛭 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕱 Natural 5 Pending s after death. 2 🗆 No Investigation Could not be Accident completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title DPP35267 9-28-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th St. Frederick, MD 21701

DHMH 17 Rev 7/2009

State Registrar

Casiano

Manvel

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	/larylar		artment of l <i>rtificate of</i>			/lental	Hygier Reg. I	211	10	32397
п	Dhysia	ion	1. Decedent's Name (First, Midd	le, Last)		_				2. Date of		Day	Year	3. Time of Death
	Physic /Medi		Warren George	crudup Jr	•					09			10	10:00A M
44	Exami		4a. Facility Name (If not institution	n, give street and numbe	er)		4b. City, Town,	or Locatio	on of Death			4c. County	of Death	
			Ft. Washington				Fort Wa					rince		
	Funeral		5. Social Security Number	6. Sex 7. A 1X M 2 □ F		last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. S Min.		of Birth h, Day, Yea	ar)	Birthp Cour	place (State or Foreign ntry)
	Director		579-62-2812 Usual Residence of Decedent		63	115.				12	22	1946		D.C.
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				_	10d. Inside City Limits		
	with the Maryland a or 28a-f show	ţ	MD Prince	George's	For	t Wash	ington							1X Yes 2 □ No
	1 28a	Director	10e. Street and Number	George 5	FUL	C Wasii	10f. Zip Code				10g.	Citizen of V	Vhat Cour	ntrv?
	3a ol		1726 Taylor Ave	enue			20744				1	USA		,
	ifter death wi r items 23a ir r millin	Funeral	11. Marital Status		t Ever in U	.S. 13. \			Origin? (Sp	ecify Yes o	or No-		e - Americ	can Indian,
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Eventral to te offited at		1 ☐ Never Married 2 ☐ Mar	12. Was Deceden Armed Forces ried 1 Tyes 2	•? ¶No	'	Vas Decedent of I			Rican, etc	.)	Blac	k, White,	etc.
03	ral",	b	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		□Yes 2X No	Spec	ify:			Specify	Bla	ck
Maryland 21215-0036	Jwithin 72 hours giene. r than "natural"; the Medical Exe	Completed	15. Deceder	it's Education st grade completed)		16a. Deced	lent's Usual Occu	pation	ant of work	ina	16b.	Kind of Bu	siness/Ind	dustry
21	ithin na. nan."	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done OO NOT use retire	ed)	IOSE OF WORK	rig				
21	filed withi Hygiene. other than ent, inc.	Š		5+		C	lergy					Chu	ırch	
pu	tal H d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mo	ther's Name	First, Mi	ddle, Maid	en Surnam	Θ)	
Уlа	Men Men arke	ပို	Warren George (Crudup Sr.				Pa	rthen	ia Tu	rner			
<u>ar</u>	ages 1 and 2 should be filed wi ent of Health and Mental Hygien t: If item 27 is marked other th y or other traumatic event, the		19a. Informant's Name/Relations			19b. Mailin	g Address (Stree	t and Nur	mber or Run	al Route N	umber, Cit	y or Town,	State, Zip	Code)
2,	and lealth m 27		Kauren Crudup/	Daughter			Taylor A	ve.	Fort	Washi	ngtor	ı, MD	2074	4
Ore	Jes 1 t of H If ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 Demoval from State		Place of Dispo cemetery, cren	sition (Name of natory or other pla	ice)		Date	20c.	Location -	City or To	wn, State
Ξ.	Pag meni ant: ury c		4 □ Donation 5 □ Other (S			Linco	ln Cemet	ery	10/0	2/201	0 Bre	entwoo	od, M	D
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service	Licensee			. Name and Addre							
<u>=</u>	⊈ <u> </u>		that ?	holeison		42	17 9th S	tree	t NW	Washi	ngtor	n, DC	2001	1
			23a. Ent the disease, or ock, or heart failure. List	complications that cause only one cause on each	line	4 .			^	or respirate			-33-71	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Athr	eroso	lerott	2 Cor	Ohavi	A	rter	14	Disea	ise	Onset and Death
	/Medical		resulting in death)	Due to (or a				-	,		1	~		
	Examiner		Cognostially list souditions	h										
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	rans acque	Examiner	triat iriitiated events	С										
68760,	e exe	ŭ	resulting in death) Last	Due to (or a	s a conseq	uence of):								
376	icate be executed physician and the burial-transit	edical		d										
39	ertific ing pl		IF FEMALE:	T			<u> </u>							
Box	eath certifi attending p for use as	Physician/M	23b. Was decedent pregnant	23c. If yes, outcom 1 \square Live birth			Ectopic pregnanc	~v				23d. Date	e of delive	ery
Э.	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant 9 ☐ Unknown	at time of o		Other (specify)	-у			_	Moi	nth	Day Year
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Ś	w requires that the de been signed by the should be detached	by F	Part II. Other significant condition			ulting in the un	derlying cause giv	ven in Pa	rt I.	23e. I	Did tobacc	o use contr	ibute to th	ne cause of death?
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0	ding Ph h. After th funeral	Ë	27. Manner of Death	28a. Date of Inj	iurv	28b. Time of	28c. Inju Wor					jury occurre		//
Division	ath. r: Aft e fun	ațio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		ay, rear)	Injury		1k?]Yes 2:	□No					
Vis	Afte ir deg ecto by th	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of In	jury - At ho	me, farm, stre	et, factory, office		:	28f. Location	on (Street	and Numbe	er or Rura	l Route Number,
Δ,	afor s afte Dir	ert	4 L Homicide	building, e	itc. (Specif	<i>y)</i>				City or	Town, Sta	ate)		
	spit hours inera y fille		29a. Certifier 1 Certifyir	g Physician: To the bes	t of my kno	wledge, death	occurred at the ti	ime, date	and place,	and due to	the cause	e(s) and ma	nner as s	tated.
:	To the hospital of Attending Physician: The law requires that the death certificate be executing 24 hours after death. No the Funeral Director, After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial-from the properties of the properties of the purial-from the properties of the pro	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examina	tion and/or inv	estigation, in my	opinion, c	death occurr	ed at the t	me, date a	and place, a	and due to	the cause(s)
	Within To the confidence of th	Me	29b. Signature and title of certific			1	29c. Licens	se numbe	er		29d. [Date signed	(Month, i	Day, Year)
	5		191	//////	1	mD	De	167	741		5	potpi	uber	27,2010
		-	30. Name and address of person	who completed cause of	death (Item	1		1	• ,			Ch C.		- 1
			n	1			gston Ro	l. Fo	ort Wa	shine	ton.	MD :	20744	ŀ
	Sta	te	31. Date filed (Month Day, Year)								, ,			
	Registr	ar	SED 302	nin 12 but	, 1.	fac								

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			For State	State of M	laryland /	-	rtment of H		and Me		2	010)	323	αΩ
			Registrar 1. Decedent's Name (First, Middle, L	ast)		Cel	uncate of D	eau i		2. Date of Dea	Reg. No.	. 0 1 0			
	Physicia Medic		Edna Helen Carrol	1						Month eptember		2010 Year		3. Time of I 5:05 a	
,	Examin	er	4a. Facility Name (if not institution, gi	,			4b. City, Town, or		Death			County of Dea			
			Brooke Grove Nursin 5. Social Security Number 6.		ge (In yrs. last b	inthalas (Sandy Spr	ing If Under 2	A Hro To		Montgomery Birth 9. Birthplace (State or Foreign				
	Funeral Director		218-38-5359	1 M 2 18 F	93	Yrs.	Months Days	Hours		B. Date of Birth (Month, Day uly 27,	1917	g. Bi	irthplac o <i>untry)</i>	C State or	Foreign
	nd how at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation					_	10d	. Inside City	/ Limits
	arylar sa-f s ified	ectc	MD Mont	gomery		aton							1.00	1 Tes	
	or 28	ä	10e. Street and Number	gonery		acar	10f. Zip Code			Т	10g. Citize	en of What C	ountry		
	with s 23a ust b	Funeral Director	2900 Dawson Avenu	е			20902					USA			
	death item	Fur	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of His Yes, specify Cuban	panic Origi	in? (Specif	y Yes or No-	14	1. Race - Am			
36	after (Il", or xamir	d by	1 ☐ Never Married 2 ☐ Married 3xx Widowed 4 ☐ Divorced	1 ☐ Yes 2¾24 If Yes, Give			Yes 2 No		T dono The	ouri, etc.,	Sı	Black, Whi pe <i>cify</i> Whit			
8	nours latura ical E	ete	15. Decedent's	Year or Dates.	16	Sa. Deced	ent's Usual Occupa	tion				d of Business		to.	
215	n 72 h e. ian "n Med	Completed	(Specify only highest selementary/Seconday (0-12)	grade completed) College (1-4 or		(Give k	ind of work done du NOT use retired)	iring most o	of working	- 1	TOD. KING	J OI BUSINESS	s muus	su y	
2	withi ygiene her th		12				Secretary			1	Defens	e Contr	act	or	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "matural", or items 23a or 28a-f show amportant in i	To Be	17. Father's Name (First, Middle, Last John M. Sobotka)						First, Middle, M Cheaffer		rname)			
ary	hould and M s mar		19a. Informant's Name/Relationship	(Type, Print)	19	9b. Mailing	Address (Street ar		_			own, State, Z	ip Coa	le)	
Σ,	nd 2 s lealth m 27	١,	James R. Carroll, I	II/Son 			Dawson Aven	ue, Whe	eaton,	MD 2090)2				
lore	ge 1 and the street of the street or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		ceme	tery, crem	ition (Name of atory or other place)	Oct Date			ation - City o		, State	
Ħ.	uit. Pa	1	4 Donation 5 Other (Spec		Cedar	_	Cemetery	(5)				and, MD)		
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			23a. Part 1. Enter the disease, or col shock, or heart failure. List only	mplications that cause one cause on each line	d the death. Do	not enter	the mode of dying,	, such as ca	ardiac or re	espiratory arre	est,			oproximate terval Betw	
	nysician/	3 1	Immediate Cause (Final disease or condition	Chronic	Renal In:	suffic	ciency						0	nset and De	eath
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Xo	ath or atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No	1 Live Birth 4 Pregnant a	2 Fetal dea		Ectopic pregnancy Other (specify)				23	d. Date of de Month	elivery Da	y Ye	ar
B	the de	hysi	9 Unknown	9 🗌 Unknown											
<u>G</u>	that gned k	by P	Part II. Other significant conditions Depression, Epileps	contributing to death b	out not resulting	g in the un Renal	derlying cause give	n in Part I.		23e. Did tot	pacco use	contribute to	o the c	ause of dea	ath?
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ono	ending eath. or: Afto ne fun	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		y, Year)	injury	M 1 □ Y	es 2 🗆 N	10						
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Completed Birector: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ury - At home, f c. (Specify)	farm, stree	t, factory, office		28f	Location (St. City or Town		lumber or Ru	ıral Ro	ute Number	r,
Ω	spital		29a, Certifier 1 K Certifying Ph	ysician: To the best of	my knowledge	e, death oc	cured at the time, o	date and pla	ace, and d	ue to the caus	se(s) and r	manner as st	ated.		
	he Ho iin 24 l he Fu ipleted	Medical	(Check 2 L. Medical Exar	niner: On the basis of e rse Practioner: To the	xamination and	or investig	ation, in my opinion	, death occu	urred at the	time, date an	d place, ar	nd due to the	cause	s) and mann I.	ner stated.
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	2		- Euff	ulu				599	+/	5	PATEN	n BEN'	48	120	10
	-		30. Name and address of person who Evelyn D. Jackson,	MD 5540 Te	en Oaks E	Road,	Clarksville	e, MD 2	21029						
		State Registrar SEP 3 0 2010 32 legistrar's Signature SEP 3 0 2010 Separation of the state of th						es de la companya della companya della companya de la companya del							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 300 M manue D 2010 Medical 4a. Facility Name (if not institution, give street Examiner 4b. City, Town, or Location of Death 4c. County of Death Hermi mont 1 m 3 ver Omer 6. Sex 1 1 M 2 D F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Firthplace (State or Foreign **Funeral** Months Days Hours Min. Dec. 24, 1949 El^{un}salvador 579-15-4843 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 🗆 Yes 2 🛱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 Hermitage Avenue 20902 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 ★ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ¥ Yes 2 □ No Specify. Salvadorian White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isabel Cruz Susan Unknown 19a. Informant's Name/Relationship (Type, Print)
Marcos A. Melendez/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9416 Victoria Street, Manassas, VA 20110 Date 1, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 K Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature Funeral Se lice Licensee 22. Name and Address of Eacility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Jandt Laten 23a. Part¹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of, if any leading to infined cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No perform death? this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one, 1 Yes 2 🗌 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral Phospital or Attending Ph 24 hours after death. Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner/To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ature and title of cert 29d. Date signed (Month, Day, Year) mo OME 010S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) La mo 31. Date filed (Month, Day, Year,

State Registrar Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#20 open FH, 9/29/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Ringer Cranford September 2010 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Alfred House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year,
1arch 3, 1 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Director 578-20-6499 88 March Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD Rockville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1994 Millboro Drive 20854 USA death 1 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Page 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White If Yes, Give Specify: 3 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Scientist Defense Documentation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Wilson Cranford Selma Delle Hout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Linda Reed/Daughter 12329 Diploma Drive Reisterstown, Maryland 21136 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Arimeter on National Arimeters artment of ortant: If it injury or o 1 🔀 Burial 2 🗆 Cremation 3 🛣 Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facilitemeaine Funeral Home Der Imr any eenhut MO1597 5308 Backlick Road, Springfield, Virginia 22151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Dav Pregnant at time of death 5 Other (specify) Yes 2 No signed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate Yes 2 the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examine? Hospital: Other: 2 No ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending ☐ Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the only one) 29b. Signature and title of certifie ٩ 29c. License number 29d. Date signed (Month, Day, Year) 27301 och fran (

Registrar
DHMH 17 Rev 7/2009

State

Myntasmony

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician (***)	State of Maryland / Der State of Maryland / Der Registrar 1. Decedent's Name (First, Middle, Last) Arthur H. Counts	Frtlficate of Death	Reg. No. 2 1 1 2. Date of Death Month Day Year September 26, 2010	3. Time of Death 4:22 a M
/Medica Examine	A. F. W. M	4b. City, Town, or Location of Death	4c. County of De	ath
Funeral Director	5. Social Security Number 577–03–2617 6. Sex 12 M 2 □ F 7. Age (In yrs. last birthda) 94 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 19, 1915	irthplace (State or Foreign Country) VA
Ba-f show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Montgomery Talkon	a Park		10d. Inside City Limits 1 ☐ Yes 2⁄☐ No
Iter death with the Mar items 23a or 28a-f sl	10e. Street and Number 7109 13th Avenue	10f. Zip Code 20912	10g, Citizen of What C	Country?
urs a	3 ☐ Widowed 4 ☐ Divorced	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒No Specify:	ecify Yes or No- Rican, etc.) 14. Race - Arr Black, Wh Specify:	
ed within 72 horygiene. Per than "natur: t, I Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Radio Operator	ing 16b. Kind of Business Merchant Ma	. =
d be filed antal Hyg red other c event,	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname) th Bvelyn Meade	
d 2 should the and Mer 17 is marke traumatic	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ing Address (Street and Number or Rui North Washington Stree	al Route Number, City or Town, State,	Zip Code)
permit. Pages 1 and Department of Heat Important: If item 2 any injury or other once.	20a. Method of Disposition 1 □ Burla! 2 ☑ Cremation 3 □ Removal from State	ematory or other place) Sept.	Date 20c. Location - City o 29, 010 Alexandria,	
permit. I Departm Importar any inju	21. Signature of Funeral Service Licensee	2 Name and Address of Facility Francis J. Collins Fun OO University Blvd. W.	eral Home	·
Physician	23a. Part 1. Ever the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		2 0	Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence of):	0	m	DME
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ath certification attending for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□ Ectopic pregnancy □ Other (specify)	23d. Date of d Month	elivery Day Year
w requires that the de s been signed by the should be detached i	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 ☐ Unknown
sician: The law require certificate has been s rector, page 2 should	DEPRESSION			
Physician: The this certificate al director, pag	25. Was case referred to medical examiner? 1 → Tes 2 □ No Hospital: □ Inpatient 2 □ ER/Outpatie	Other:	n <i>(Check only one)</i> ome 5 ☐ Residence 6 ☐ Other <i>(Sp</i>	necify)
ier ier	27. Manner of Death 1	Work?" 1 □Yes 2 No	28d. Describe how injury occurred Fau Down How 28f. Location (Street and Number or Fixty or Town, State)	JSGWOLK Rugal Markete Manage
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur Medical Certification	29a. Certifier (Check only (C	th occurred at the time, date and place.	and due to the cause(s) and manner	as stated.
1 11	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
PH	30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	SEPTEMBER.	-
State Registrar	31. Date filed (Mogth, Day, Year) SED 29 2010 Butter S. Am		10 ZO	912

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10-07434 William Edward			or Print in Black In of Maryland / Depa		Health an			_	10 3240
Physicia	_	Registrar 1. Decedent's Name (First, Middle, Last		runcate or L			2. Date of Dea	Reg. No. ath	3. Time of Death
Medical Exami		WILLIAM EDWARD C					Month Septemb	Day Year er 27, 2010	1408 hrs
		4a. Facility Name (if not institution, give Baltimore Washington Me			. City, Town, or Glen Burnie	Location of Death		4c. County of I	
Funeral		Social Security Number 6. Se			If Under 1 Yea		8. Date of B		9. Birthplace (State or
Director			M 2 F 59		Months Day		1	` [F	oreign MARYLAND
		Usual Residence of Decedent					DODI J	1, 1)51	
ow any		10a. State 10b. County		, Town or Location					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show 1 at once.	햠	MARYLAND QUEEN AN 10e. Street and Number	NE'S	CHESTE	R 10f. Zip Code			10g. Citizen of What	
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with ms 23a be not		11. Marital Status	12. Was Decedent Ever in U	I.S. 13. Was [Decedent of His	spanic Origin? (Sp	ecify Yes or No	o- 14. Race - A	American Indian, Black,
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)036 within ene. er tha	Completed	12	2	EQUIPME				HOSPITA	ALITY
filed vill Hygined oth	Be Co	17. Father's Name (First, Middle, Last) WILLIAM EDWARD CO	MECVC CD			18.Mother's Name			
212 212 Ments Ments mark		19a. Informant's Name/Relationship (Ty		19b. Mailing A		MARY ETH		nber, City or Town,	State, Zip Code)
MD d 2 sho lth and n 27 is numati	- 1	KATHY COMEGYS/WIFE					ESTER,	MARYLAND,	21619
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Cremation 3		Place of Disposition ESAPEARIE			Date 1	20c. Location - Ci	ty or Town, State
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프트등등등	- 1	21. Signature of Funeral Service Licens							
Ba Perm Depa Impo	Į	/ / / / / /	iee .						L HOME, P.A.
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F Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed mapping the strength of the attending physician and trincate has been signed by the attending physician and transit and deached for use as the burial - transit	edical Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complifaiture. List only one cause on ear Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physicial One) 29 Medical Examiner:	ications that caused the death at line. Multiple Blunt Force Inj Due to (or as a consequence of Due to (or as a consequence	I 106 Do not enter the uries off): Inancy 2 Fetal ath 5 Other esulting in the und 28b. Time of Injut 1321 hrs Dome, farm, street, f d / Highway ge, death occurred	SHAMRO mode of dying, death 3 [r (Specify) 26.Place DOA ry 28c. Injur 1 V 1	Ectopic pregnar Ectopic pregnar jiven in Part I. of Death (Check of Other Mark Nursing y at Work? Yes 2 No vite and place, and of the place and place, and place	CHESTE respiratory arr 23e. Did to 1 Yes 24a. Was autop perfo 1 Yes 28d. Describe l Pedestrian s 28f. Location (s or Town, S Vestbound R due to the caus	23d. Date of del Month bacco use contribut 2 V No 3 an 24b. Wer pnormed? 2 No 1 V Residence 6 C cow injury occurred struck by motor Street and Number of late) t. 50, Annapolis, Me(s) and manner as	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Interval Probably 4 Unknown The autopsy findings available into completion of cause of the cause of the cause

State Registrar DHMH 17 Rev 1/2001 OCME 2006

bark

36. Name and address of person who complete cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Russell Alexander MD.

31. Date filed (Month, Day, Year) SEP 29

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 26, SHIRLEY MAE COVER 2010 4:02 A . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 126 SOMERSET ROAD STEVENSVILLE OUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Hours Min 80 AUGUSTII 1930 **Director** MARYLAND 212-28-8296 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified 1 🗌 Yes 2X No QUEEN ANNE'S MARYLAND STEVENSVILLE ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 126 SOMERSET ROAD UNITED STATES 21666 items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than 'traumatic event, the Me permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CLARENCE E. BREWER MARY HAMPSHIRE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 SOMERSET ROAD, STEVENSVILLE, MARYLAND 21666 JOHN F. COVER, SR./HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARERY CRITICAL TON SEPT 2010 CENTER 2010 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signatur Funer Prvice Licen 22. Name and Address of Facility FELLOWS FUNERAL HOME, P.A., 106 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Ente Approximate Interval Between Immediate Cause (Final Physician/ Pancreate Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and as the burial-tran Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed?

Yes 2 No After this certificate 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital: 2 📑 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name_and a dress of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Date filed (Month, Day, Year)

SEP

Stevensvilly

21666

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Marv Α. Coleman 2010 4:45A October 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince Georges Bradford Oaks Nursing & Rehab. Clinton Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2√2 F Yrs 577-40-5784 83 Jan. 26, 1927 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20032 619 Darrington St., SE United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Binder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Harrison Rosa Gilliam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 619 Darrington St., SE Washington, DC 20032 Rosa Robertson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/8/10 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery Brentwood, MD 21. Sign ur of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1. Enter the disease, or comshock, or heart failure List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Ceuse (Final Anteniosclarità disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 XNo 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **Y**+10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Aatural

burial-transi nding physician and use as the burial-tran P.O. Box 68760, certificate be use as atten for u requires that the death signed by the a of Vital Records, should I has certificate Physician: this After thi funeral of

Division or Attending

death.

after

the Hospital

Exami Physician/Medical Ş Completed Be ၉

Physician

/Medical

Examiner

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27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Movical Examiner must be notified at

Department of Health a Important: If item 27 Is any injury or other trauonce.

Physician

/Medical

Examiner

Pages 1 /

and 2 should be filed within 72 hours after death itealth and Mental Hygiene. m 27 Is marked other than "natural", or items 23.

Saltimore, Maryland 21215-0036

IF FEMALE:

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Certification: neral Director: / filled in by the f

Medical

within 24 hours a 4

State Registrar

(aus & snuc mm William

D35206

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OCTURE 2, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingshe Road. Fort WASHington wrong/and

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

5.2010

32. Registrar's Signature

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	Marylan		artment of I		Mental Hy	/giene	010	00105
			Registrar 1. Decedent's Name (Fig.	irst, Middle, Las	·)		Cer	tificate of L	Jeath	2. Date of De	Reg. No.	UIU	3. Time of Death
	Physicia Medio		Audrey	В.	D _.	ysland						2010 Year	5:00 p M
8-1	Examin		4a. Facility Name (if not	_		per)		4b. City, Town, o		th	4c. C	ounty of Death	
**	Funeval		Brighton Ga: 5. Social Security Numb			'. Age (In yrs. Ia	ast hirthday)	Columbi		s. 8. Date of Bi		ward	
	Funeral Director		215-44-2629	1 [☐ M 2 🔼 F	89		Months Days	Hours Mir		y, Year) 1920	Vas	place (State or Foreign http:) nington, DC
	show d at	호	Usual Residence of Dec 10a. State 10t	b. County		10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
	e Mary 28a-f notifie	Jirec	MD	Montgo	mery	Si	lver Spi						1 🗌 Yes 2 🎦 No
	with the 23a or	Funeral Director	10e. Street and Number 1907 Augus					10f. Zip Code 20902			10g. Citize USA	en of What Cou	ntry?
920	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 Never Married 3 X Widowed 4		12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dat	es? 2 🔀 No	If	√as Decedent of H Yes, specify Cuba	ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)		1. Race - Ameri Black, White, pecify: Whit e	etc.
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2121	within 7, rgiene. her than t, the Me		Elementary/Seconda		College (1-4	or 5+)	life. DO	NOT use retired)	Officer	,,,,,,,,			bhol, Tobacco Federal Govt.)
altimore, Maryland 21215-0036	age 1 and 2 should be filed went of Health and Mental Hyg t: If item 27 is marked othe r or other traumatic event,	To Be	17. Father's Name (First, Thomas Seymon						18. Mother's Na	ame <i>(First, Midd</i> le, e White Ki	Maiden Sui ng	mame)	
, Mar			19a. Informant's Name/ John T. Dysla	and/Son	oe, Print)		19b. Mailin	g Address (Street a Schubert Dr	and Number or R	ural Route Numbe er Spring,	er, City or To MD 209	own, State, Zip 9 04	Code)
timore	permit. Page 1 a Department of H Important: If ite any injury or oth	- 3	20a. Method of Dispositi 1 🙀 Burial 2 □ C 4 □ Donation 5 □	Cremation 3 🗆		tate c	emetery, crem	ation (Name of atory or other plac prial Park	e) Oct	Date 010'		ation - City or T	
Bal	permit Depart Impor any in	(i	21. Signature of Funeral	Service License	lle	e/	22 Fr 500	Name and Addressincis J. C Universit	s of Facility Ollins Fu y Blvd. W	neral Home , Silver	Inc. Spring,	,MD 2090]	
-	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death			
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09/	physician an	dical			d					<u> </u>			
687	certifica nding parse as		IF FEMALE: 23b. Was decedent preg	onant 2	3c. If <u>ye</u> s, outco						224	d. Date of deliv	
). Box 687	hat the death certific ed by the attending I detached for use as	Physician/M	in the past 12 mont 1 Yes 2 No 9 Unknown	ths?		nt at time of d		Ectopic pregnanc Other (specify)	y 		230	Month	Day Year
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Recor	rsician: The law rec s certificate has ber lirector, page 2 sho	Completed								24a. Was autop perfo 1 ☐ Yes	osy ormed?	24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of
ta	nding Physician: 1 th. : After this certifica : funeral director, p	Be	25. Was case referred to examiner?	107	ospital:		-13		ce of Death (Che				
Ž	Physical this care and direction	은	1 Yes 2 X No) ''	1 ☐ In 28a. Date of	patient 2 🔲 I	ER/Outpatient 28b. Time of	3 DOA Othe	4 ☐ Nursing I	Home 5 Resid	dence 6 1x		intring
O LO	ending sath. or: After ne fune	licate	1 X Natural 5 [2 Accident	Pending Investigation	(Month,	Day, Year)	injury	work	Yes 2 No	28d. Describe h	iow injury oc	ccurred	
Divisi	FEMALE 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 3 Proposed by the past 1								Route Number,				
	the Hospi in 24 hou the Funer ipleted fill	Medical	(Check 2 □ N	Viedical Examin	er: On the basis	of examination	and/or investig	cured at the time, gation, in my opinion eath occurred at the	 death occurred 	at the time date a	nd place an	d due to the ca	ise(s) and manner stated
			29b. Signature and title of	. /. \	rmila			29c. License				igned (Month,	** **
	30	}	30. Name and address of	•		of death (Item	23a) (Type, Pri		30641 Ramesh S	abapathi,		ember 29	, 2010
			201-109 Back	River Nec	k Road, 1	Baltimor	e, MD 21	221					
	State Registra	_	31. Date filed (Month, Da)	3 0 2010	Oen u	istrar's Signatu	par	J.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Vaar Margherita S. Dinale 11:15 P M Sept. 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring House Assisted Living Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🕱 F Director 033-28-3459 Oct. 20, 1923 Italy 1 and Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits District Director 1 Tr Yes 2 □ No Washington DC of Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or 3 the Medical Examiner must be n 20015 Italy/United States Funeral 3217 Patterson St. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after deal Hygiene. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No ģ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) College Professor Smith College and Mental Hygie Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be other traumatic ဂ Luigi Silvi Adelia Silvi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Silvia Dinale/Daughter 3217 Patterson St. NW Washington, DC 20015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or or
once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 10/6/2010 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the diseasthock, or heart failure. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se/ Final disease or condit n resulting in death) Physician Liver Failure /Medical Due to (or as a consequence of): Examiner Biliary Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown ate has t een signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was a... autopsy performed? Yes 2X No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Asst.living1 ☐ Yes 2 No 1 🔲 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 🙀 Natural

5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide

determined

Injury

28c. Injury at Work? 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9/29/2010

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature an

29c. License number D35579

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller, MD 8218 Wisconsin Ave. #305 Bethesda, MD 20814

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature SFP 3 0 2010

with the Maryland

death

Baltimore, Maryland 21215-0036

ould be f

Pages 1

certificate be executed

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

death.

24 hours after death e Funeral Director: completely filled in by the

To the Pwithin 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No 1 Decedent's Name (First Middle Last 2. Date of Death Physician/ Wilbur Edward Davison September 27, 2010 ear 2:47 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Assisted Living Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country) RI 1 ₺ M 2 🗆 F Aulgonth 25 Y 1928 Months Days Hours Min Director 039-12-4464 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Takoma Park 1 Yes 2 No Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 901 Elm Avenue 20912 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 it Yes, Give WTT-1989 Year or Dates. 1 ☐ Yes 2 No Specify. 3 ₺ Widowed 4 □ Divorced Specify: White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) CWO 4 Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Burton Davison Ruth Elizabeth MacQueen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7245 Riding Hood Circle, Columbia, MD 21045 Michael Thomas Davison/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 2010 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature A Funeral Service Licensee rgişd^{jddr}esin^FfGE^yFuneral Home Inc. University Blvd. W., Silver Spring, MD 20901 Mehand L Hates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transii Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Pregnant at time of death Month Year 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page performed' death? certificate Yes 2 No To the Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣ No Other: |은 After this of funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🖺 Natural 5 Pending Accident 1 Yes 2 No Director: / Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) hin 24 hours aft the Funeral Di mpleted filled ir Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Warse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) D47447 Sept. 29, 2010 15+1 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 Cedar Lane, Columbia, MD 21044 Andrew Lazris, MD 31. Date filed (Month; Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar 32408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1704 P M Ranjeeta Das ptember 26,2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Hospital montgomery Adventist Rockville 8. Date of Birth
(Month, Day, Year)
Tuly 26, 1 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours Min. Country) India 58 Yrs. **Director** 211-52-0559 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits Director notified Maryland Montgomery Derwood 28a-f 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 7744 Epsilon Drive 20855 India Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten I Examiner r 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates Asian Indian 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker <u>Own Home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hrudayananda Sahoo Annapurna Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amiya K. das (Spouse) 7744 Epsilon Drive, Derwood, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 2. 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2010 Germantown, Maryland Souls Cemetery 21. Signature of Funeral DeVol Funeral Home, 22. Name and Address of Facility M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Hart 1 Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ myocardial Medical Due to (or as a consequence of) **Examiner** atheroscleratic coronary See year finite flet ever little on Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and a be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes ပ္ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 24 hours after death.

Funeral Director: A 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, greating occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b, Signature and title of certifier 29c. License number 9 e and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, CFP 3 Rocleville MD 20850 MD Ctr 9901 Wenk medical 2. Registrar's Signature State Registrar

4021

2010

September

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 29,2010 ANNA REBECCA DEAN 7:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death QUEEN ANNE'S CENTREVILLE HOSPICE OF QUEEN ANNE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, NOV - 20) 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral 1 ☐ M 2 🕱 F MARYLAND Director 87 213-14-7969 Usual Residence of Deceder 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director QUEEN ANNE'S CHURCH HILL MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country Funeral er than "natural", or items 23: the Medical Examiner must 321 ROBERTS STATION ROAD 21623 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give WHITE 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME 11 HOMEMAKER Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD STANT **EVA KIMBLES** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 ROBERTS STATION ROAD, CHURCH HILL, MD 21623 HOWARD A. DEAN/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or CHURCH HILL CEMETERY OCT.4, 2010 CHURCH HILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 use as 1 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō Month Day Year 9 Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been either Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death?
1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be HOSPICE CENTER 2 No Hospital: Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 Pending Natural 2 🗌 No Accident

3 Suicide

4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10056076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 202 COURSEVAIL DRIVE, SUITE 101, CENTREVILLE, MD 21617 PATRICIA BOWYER, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Harry Edward Dice, Jr. 2010 1:35 Рм September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 9222 Wofford Lane College Park Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, March 4 578-40-5032 79 1931 Wilkes Barre, PA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a 1 X Yes 2 No Ocean View Delaware Sussex 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o dical Examiner must be Funeral 12 Winchester Drive 19970 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married X Yes 2 🗌 No 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 1951-1953 Specify: White Completed 3 Divorced 4 Divorced er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Contractor Master Glazier event, the it. Page 1 and 2 should be filed wi intment of Health and Mental Hygis intant: If item 27 is marked other njury or other traumatic event, t Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Edward Dice, Sr. Catherine Casey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Winchester Drive, Ocean View, DE 19970 Betty M. Dice / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1. Department of Important: If it any injury or of once. 1 🖾 Burial 2 🗌 Cremation 3 🗔 Removal from State 10/1/2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the "Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Prostate Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 as attending use 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year signed by the a 1 L Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 Yes Hospital or Attending Physician: Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work? 1 X Natural injury Accident 5 Pending after death. investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined City or Town, State) Medical

within 24 ho To the Fune 12+, 29a. Certifier

(Check

only one

з 🗌

29b. Signature and title of certifier

7525 Greenway Center Drive, Suite #205, Greenbelt, MD 20770 Martin D. Weltz, 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State OCT 0 4 2010 Registrar

re low

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D23743

29d. Date signed (Month, Day, Year)

9/29/2010

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 3<u>0</u> 3. Time of Death Physician/ Month David September 2010 6:39 p Jerome Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Maryland Hours 1 1 M 2 | F Director 212-66-5236 54 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's 1 Yes 2 No Lexington Park 10e. Street end Number 10g. Citizen of What Country? Funeral 20653 USA 21993 Fox Ridge Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian ģ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: "natural", Completed 3 Widowed 4 Divorced Black Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve ပ Ε. Johnson Charles R. Estep Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21560 Gordon Ct., Lexington Park, MD 20653 Davida Estep/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Charles Memorial Grd 10/08/2010 Leonardtown, MD Signature Feneral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ avdice disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ox, Sequentially list conditions, if any, leading to immediate Examine Due to (or as a confequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 s after deau...
ral Director: After this cer.... 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death once d at the time, date and place, and dive to the cause(s) and manner as stated 29b. Signature and tipe of certifie 29c. License number D60177 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) La Ger KO 1 10 Oax L. Conard town 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-07565 James Allen Fox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 32412
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.										
Physici	an/	Decedent's Name (First, Middle, Last)					2. Date		. ٧		3. Time of Death
edical Exami	iner	James Allen Fox					Month Octo	ր Day ber 2, 20	y Year 110		0255 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City,	Town, or	Location of	Death		4c. County o	f Death	
		1FO 508 North Main Street		Boor	nsboro				Washing	ton	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Un	der 1 Year	If Under	24Hrs. B. Date	of Birth(M	M/DD/YYYY)		thplace (State or
Director		214-86-9442 1 X M 2 F 5	52 y	rs. Mont	ths Days	Hours	Min. Jul	v 20,	1958	Foreig Co	n untryMaryland
		Usual Residence of Decedent				1				L	4
any			y, Town or Loc	cation			·				10d. Inside City Limits
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36 in 72 han "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Indep	ondon	t Co	ntract	or	Ι,	Newsna	ner	Company
with with her t	шo	17. Father's Name (First, Middle, Last)	Tildep	enden			Name (First, Mi		_		
11215-0036 And be filed within 72 hours after filed Within 72 hours after an "engural", and the from "instural", event, the Medical Examiner.		Philip Lowell Fox, Sr.					a Jane 1		sii Suitiaille)		
21215-0036 Mult be flied within 72 hours after Mental Hygiene, marked other than "natural", ic event, the Medical Examiner.	To Be	19a. Informant's Name/Relationship (Type, Print)	19h Mail	ling Addres	s /Street		er or Rural Rou		City or Town	State	Zin Code)
MD 2 d 2 shou lith and I m 27 is r aumatic	-	Peggy K. Fox - Wife		_	-	a Ave			ort,MD		
			Place of Disp				Date		Location -		
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Baltimore, permit. Pages I ar Department of He. Important: If ite		21. Signature of Funeral Service Licensee					Osborn				
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Physician /Medical		failure. List only one cause on each line.		i ille mode	or dying,	such as can	diac or respirate	ny arrest, s	HOCK, OF HEA		Between Onset and
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K 68 1 cert endir use a	cia	Pregnant at time of de	aath =	Other (Spe			· · · · · · · · · · · · · · · · · · ·		***************************************		-,
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The physician of the serificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	Suicide Could not be determined (Specify) Maior Doo			y, omeo be	indirig, cto.	or To	own, State)	in Street, E		
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Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	lica	(Check only one) 2 Medical Examiner: On the best of my knowled									
To Com	Medical	and manner stated. 29b. Signature and title of certifier		29	c. License	number		290	I. Date signe	d (Mon	th, Day, Year)
	_	O MA			O.C.N	1.E.			tober 2, 2		
		20 Name and address of a second state of the s	n 23a'								
54-4		30. Name and address of person who completed cause of death (Iten Jack Titus MD. Deputy Chief Medical Examine		enn Stre	et. Balti	more, Mi	D 21201				l
770		31. Date filed (Month, Day, Year) 32. Tegistrar's Signat		المرا	J., - WILL						
St	tate	Oz. January	A A	All Control	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 25, Foge1 Julius 2010 2:24 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4701 Willard Avenue, #913 Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F 08¹/25²/1²9¹13 Virginia 578-40-0264 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Directo Chevy Chase MD Montgomery 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 20815 4701 Willard Avenue, #913 12. Was Decedent Ever in U.S. Armed Forces? 1 ₺ Yes 2 □ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. Army 1 Yes 2X No Specify: Specify Completed 3 ₺ Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work dane during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical 5+ Physician and Mental Hygier 7 is marked other 1 Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hv.
Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Morris Fogel Fanny Fromowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Bethesda, MD 20852 11111 Buckwood Lane David Fogel-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg, MD Garden of Remembrance 09/26/2010 4 ☐ Donation 5 ☐ Other (Specify) d Sagel Funeral Direction, Name and Address of Facility Edwar nc. 1091 Rockville Rockville, MD 21. Signature of Funeral Service Licensee non 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 15 Years Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be exeruted that initiated events resulting in death) Last Due to (or as a consequence of): -burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural iniury work? 1 🗌 Yes 2 🗎 No 5 Pending s after death. Accident Investigation 6 Could not be 3 [Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) September 25, 2010 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

Thomas S.

31. Date filed (Month, Day, Year)

5530 Wisconsin Avenue, #515

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goldbaum,

29 2010

MD

🙎. Registrar's Signature

D30885

Chevy Chase, MD 20815

DHMH 17 Rev 1/2001

Registrar

			Please Type or P amend 321 Per FH G90 FoAmend Item 5 State of I	rint in I 10/ Marylan	Black Ir 15/10 g./Depa	ndelible Inl	k. Ensure lealth and	All Copies	Are Leg	jible.			
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		or	Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc	eation		0d. Inside City Limits					
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	s 23a nust b	Funeral	112 Orchard Drive			21713			U.S.A	. •			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 1 ☐ Yes, Give	?	If	Vas Decedent of Hi f Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White, e	etc.		
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Maryland 21215-0036	l within 72 ygiene. her than "i t, the Med	Be Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of 1.2)	r 5+)	life. DO	kind of work done of NOT use retired)	luring most of wo	orking		Own Home			
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	d 2 sh atth a atth a r 27 is er trau		Norman F. Goetz / Husband		•		onsboro,	-		21713			
ore	ge 1 and t of Heal If item 3 or other		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from Sta		Place of Disposemetery, crem	sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	wn, State		
Baltimore,	permit. Page 1 Department of I Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)	Sta		Cremator		05/2010					
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. Box 68760	Attending Physician: The law requires that the death certificate be ex ar death certificate has been signed by the attending physician ctor. After the funeral director, page 2 should be detached for use as the buria	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta tat time of d	al death 3 🗌	Ectopic pregnanc Other (specify)			23d. Da	ate of delive	ery Day Year		
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	To the within To the comp	-	29b. Signature and title of Certifier			29c. License			29d. Date signe				
			Jue Ju	va		100	050	521	10/	1/10)		
3H	-2		30. Name and address of person who completed cause of Marc Kross, MD 1136 Opa			rint) gerstown	, MD	21740	/	/	1		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Fegis	trar's Signat	ture	add							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Andrew Stephane Gallia Jr. September 2010 3:35 Medical 4c. County of Death St. Mary's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Leonardtown St. Mary's Nursing Center 9. Birthplace (State or Foreign Country)District of Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Director 87 578-20-3373 May 12, Usual Residence of Decedent f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Hollywood 1 Yes 2 No St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20636 24669 Greenview Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 x Yes 2 ☐ No If Yes, Give ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify:White 🗌 Yes 2 🔀 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry United States (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government 12 Electronics Technican Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl L. Goode Andrew S. Gallia, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20650 24669 Greenview Drive, Hollywood, Maryland Regina Gallia/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 5. St. John's Catholic 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Hollywood, Maryland <u>Cemetery</u> 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 23a. Part | . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** LOTY Usque itiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 🗹 No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s 1 Yes 2 No filled in by the funeral director, To Be 25. Was case referre o medical 26. Place of De h (Check only one) examiner? Hospital: Other: 1 🗆 Yes 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier NRRD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annopolis, MD 2140

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 2010 Nora Mary Glenn 9:30 P M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 19880 Piney Point Road Valley Lee Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea May 7, 1921 1 M 2 X F Months Hours Min. 89 Yrs. Maryland Director 218-16-2573 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Valley Lee St. Mary's Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral USA 20692 19880 Piney Point Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 X No Specify. Specify.Black 3 X Widowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7. Ih and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17 Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) ပ William Shade Lillian Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 5214 Leverett Street Oxon Hill, Maryland 20745 Helen Pegues/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ST. George's Catholic October 11, 4 Donation 5 Other (Specify) Valley Lee, Maryland Cemetery 2010 21. Signature of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Michael P.O. Box 270, Leonardtown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, in the conditions cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): ŵ resulting in death) Last burialattending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 🛍 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 N death? Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director, Al 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of

James P. 31. Date filed (Month, Day, Year)

Jarboe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records.

of Vital

Division

24035 Three Notch Road Hollywood, Maryland

29c. License numbe

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Examinar must be rotified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	for State Registrar		State of	Marylan		artment of F <i>rtificate of l</i>		rientai Hy	'gien Reg. N	Z U	0	32418	
	Decedent's Name	(First, Middle, Las	st)					2. Date of De				3. Time of Death	
an	Bijan Ghova	nlou						Month 9	D	22	Year 10	10:25A M	
al	4a. Facility Name (If		e street and num	nber)		4b. City, Town, or	Location of Death		4	c. County	of Deat	h	
er	Suburban Ho			,		Bethesda			Montgomery				
	5. Social Security N		ex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, D	rth V	-1	9. Birt	thplace (State or Foreign	
	579-66-4059	1	X M 2 F	7	4 Yrs.	Months Days	Hours Min.	10/20/	1935	()		untry) Iran	
	Usual Residence of	Decedent											
	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits	
cto	MD	Montgomer	су	Poto	mac							1 □ Yes 2√ No	
ire	10e. Street and Nun	nber				10f. Zip Code			10g. 0	Citizen of	What Co	ountry?	
Funeral Director	10412 Democ	racy Blvd.				20854			USA				
ner	11. Marital Status		12. Was Dece		S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No)-			erican Indian,	
I.	1 Never Marri	ed 21 Married	Armed For 1 ☐ Yes	2 📆 No		1 ☐ Yes 2 X No	Specify:	nican, etc.)			ck, White	ite	
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၉	Mohammed Za	man Ghovan	lou				Fakhri Far	zanegan					
	19a. Informant's Na	ame/Relationship (Type. Print)		19b. Maili	ng Address (Street	and Number or Rur	al Route Numb	er, City	or Town	, State, 2	Zip Code)	
	Roya Marcel	lle - Daugh	ter		2335	N. Van Bure	n Ct. Arl	lington,	VA 2	2205			
	20a. Method of Disp		1-	20b. F	Place of Dispo	osition (Name of matory or other place	e) [Date	20c.	Location	- City or	Town, State	
		☐ Cremation 3 ☐ 5 ☐ Other (Specif		state			1	2010	Fa	lls C	hurch	ch, VA	
4 Donation 5 Other (Specify) National Memorial Park 9/26/2010 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home													
Mational Funeral nome National Funeral nome 7482 Lee Hwy., Falls Church, VA 22042													
	23a. Part 1. Enter th	ne disease, or com	plications that ca	used the deat		ter the mode of dyir	g, such as cardiac	or respiratory	arrest,			Approximate Interval Between	
	Immediate Cause (rt failure. List only Final	15-									Onset and Death	
	disease or condition resulting in death)	n	Pneumo	or as a conseq	uanaa afti								
			,			acondary to	Above						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Multiorgan Failure Secondary to Above Due to (or as a consequence of):													
Examiner	Cause (Disease or	injury	,										
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iar	23b. Was decedent in the past 12	months?	1 ☐ Live b	irth 2 🗀 Feta ant at time of c	I death 3[☐ Ectopic pregnanc☐ Other (specify) _	y				onth	Day Year	
Completed by Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown	JNo	9 Unkno			_ o ((oposy) _							
H.	Part II. Other signif	icant conditions	ontributing to de	ath but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did	tobacc	o use con	tribute to	o the cause of death?	
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on:	27. Manner of Death 1 X Natural	h 5 ☐ Pending	28a. Date of (Montal)	of Injury h, <i>Day</i> , Ye <i>ar)</i>	28b. Time o Injury	Worl	(?	28d. Describe	how in	jury occu	rred		
cati	2 Accident	investigation 6 ☐ Could not be					Yes 2 □No						
ij	3 ☐ Suicide 4 ☐ Homicide	determined	I Zoe. Place	of Injury - At ho ng, etc. <i>(Specil</i>	ome, farm, st	reet, factory, office		28f. Location City or To	(Street wn, Sta	and Num ate)	ber or R	ural Route Number,	
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cal	29a. Certifier (Check only					th occurred at the til nvestigation, in my o							
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2	29b. Signature and	title of certifier		1		29c. Licens			ا .Des	Jale sign	eu (Mon	th, Day, Year)	
	/	1	1	5		66	5264		C	17/	4	410	
	30. Name and addr	ess of person who	completed caus	of death (Iter	n 23a) (Type,	Print)							
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State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ _P ^M 2010 September Greenberg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Annapolis</u> 931 Edgewood Rd #108 Anne Arunde1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) Funeral 1 □ M 2 🗓 F Days Hours 3/4/1930 Poland Yrs Director 80 129-30-0972 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must he mattered at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Annapoli</u>s MDAnne Arundel 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 931 Edgewood Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 □ Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Accountant</u> **Accounting** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Fuchs <u> Hannah Rosenfarb</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 South Riverside Drive Crownsville MD 21032 Henry Greenberg/ Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/19/2010 Agudath Stamford, CT Sholom Cemt. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. Kurt_Blake 1170 Rockville Pike, Rockville, MD 20852 23al Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysiciani Concar 0 lou disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying ng physician and as the burial-tr-neit Hospital or Attending Physician: The law requires that the death certificate be executed Dause (Disease Or impury that initiated events resulting in death) Last Due to (or as a consequence of) led by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day 5 Other (specify) sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 24 hours after death. Funeral Director: After this certificate 2 🗌 No Yes 2 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title 29d. Date sigred (Month; Day, Year) è cause of death (Item 23a) (Type, Print) Solmons Island Rd. 31. Date filed (Month, Day, Year Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 24, 2010 Ruth Graff 9:35 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Clifton Woods Group Home Silver Spring Montgomery If Under 1 Year If Under 2 Months Days Hours 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Months Days Min. 1 □ M 2 😿 F 085-01-1334 91 07/12/1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No |Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13408 Clifton Road 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1∐Yes 2∭2No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Geriatric Elementary/Secondary (0-12) College (1-4or 5+) Guidance Clinic Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Kaplan Lena Yutan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stuart L. Graff, son 198 Halpine Road, Apt. 1241, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify)Mausoleum Star of David Cem. 09/28/2010 Tamarac, Florida 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Si natan Di Funeral Service Licensee MO1255

Physician /Medical **Examiner**

permit. Pages Department of Important: If it any Injury or o

Physician

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31. Date filed (Month, Day, Year)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If Item 27 is marked other than "natural", or items 23a or 28a-f show

altimore, Maryland 21215-0036

Ing physician and e as the burial-trans attending physician use for To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Certification: To

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

201		11091	KOCKVIIIE FIR	e, KUCKVII	re, mary.	Tana Zuoja
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal one cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Dysphagia					Onset and Death
resulting in death)	Due to (or as a consec	quence of):				
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cause. Enter Underlying Cause (Disease or injury that initiated events						
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ectopio	c pregnancy (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Dementia				1 □ Yes	2+7 No 3□ Pi	robably 4 🗆 Unknown
Dementera				1 103	- Jaj 110 0 0 1 1	
				24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
				performed 1 □ Yes 2 🔀	death?	2 \(\text{No} \)
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □	DOA Other: 4 \(\sum \) Nursing I	Home 5 ☐ Residence	6 X Other (Spe	Group cify) Home
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St.	and Number or Ri ate)	ural Route Number,
	rsician: To the best of my kno iner: On the basis of examina and manner stated.					
20h Signature and itle of certifier		3	9c. License number	294	Pate signed (Mont	h Day Yearl

D35579

September 26, 2010

DHMH 17 Rev 1/2001

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Susan J. Miller, MD, 8218 Wisconsin Ave, Suite 305, Bethesda, Maryland

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/MEND#SpeerFH, 9/29/10, EMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25,2010 September Anita Graber Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner #917 Montgomery 5107 Interlachen Drive Spring Silver 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) (Month, Day, Year) 10/29/1925 1 🗆 M 2 🗶 F Months Hours Min. Director 112-16-2151 84 Germany "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1
¥ Yes 2 □ No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20906 #917 15107 Interlachen Dr. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify If Yes Give 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot ပ Ceisia Obremski Eliot Olejer ge 1 and 2 should be not of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlive Court Rocknville, MD Norman Graber / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗆 Burial 2 💢 Cremation 3 💢 Removal from State permit. Page Department of Important: If any injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 09/28/2010 Falls Church, VA 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
Pockville Pike Rockville, MD 20852 Signature of Funeral Service Licensee <u>Blake</u> 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic nonsmall Cell Lung Cancer Physician/ months disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 K No has prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be

Box 68760 Division of Vital Records, P.O. the Hospital or Attending Physician: The law certificate To the Funeral Director: After this certific completed filled in by the funeral director, within 24 hours after death.

To the Funeral Director: After this

1 ☑ Natural 5 ☐ Pending 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not determing	ot be	injury M ome, farm, street, factor)	work? 1 ☐ Yes 2 ☐ No ory, office	28f. Location	8f. Location (Street and Number or Rural Route N City or Town, State)				
(Check 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination Nurse Practioner: To the best of m	n and/or investigation, i	n my opinion, death occur	red at the time, date	e and place, and due to the o	ause(s) and manner stated.			
29b. Signature and title of certifier		2:	9c. License number		29d. Date signed (Month	, Day, Year)			
POPE	10.0	1	M000335		Sada ha 27 2010				

Other:

28c. Injury at work?

Drive

4 ☐ Nursing Home 5 🏝 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

MD

State Registrar examiner?

27. Manner of Death

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Medical Certificate:

2 🔀 No

Bannen 31. Date filed (Month, Day, Year)
SEP 29 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury

(Month, Day, Year)

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٥

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. Nancy L. Gehring 27 201^vO^{ar} 4:30P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6300 Golden Hook Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 - M 2 XF 183-30-6104 76 Ju**YY31°,**Y**9**34 Pefinsylvania Yrs Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Tyes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6300 Golden Hook 21044 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. White 1 Never Married 2 Married þ 1 Yes within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 Divorced 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'lury or other traumatic event, the Me Elementary/Seconday (9-12) College (1-4 or 5+) banking Manager 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Edna Clark Robert S. Swank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 6300 Golden Hook Columbia, Maryland 21044 Carol A. Dempsey -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 10/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Donald V. Borgwardt Funeral Home, 4400 Powder MIII Road Beltsville, Signature of Funeral Service icense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death

Syears Physician, Parkinson's Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician shed for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 MNo
9 Unknown Dav cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia; Diabetes Type II 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 X N prior to completion of cause of death? this certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛮 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) September 28, 2010 29b. Signature and title of certifier 29c. License numbe 0 D53966 ustin M Clark MV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kristin M. Clark, M.D. 5018 Dorsey Hall Drive, #104 Ellicott City, Md. 21042

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32423 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 30 Physician/ 2010 1:50 P M Rita Hammer Hoffman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) est <u>Virginia</u> 1 □ M 2 🏝 F Months Days Hours Min. (Month, Day, Year **Director** 235-34-4959 83 West Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 Clear View Road 21791 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 TXNo 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hammer, Sr. Frank Trimboli Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Clear View Road Union Bridge, Maryland 21791 Karla Hoffman/daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it ō cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 10/2/2010 Woodbine, Maryland ture of Funeral Service License Golfing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementi Physician/ Mixed disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed burial-transi Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTN 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? rmed? 2 X No 1 🗌 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral e Hospital or Attending Pt 24 hours after death. e Funeral Director: After th Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my entities, dath and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number answiya, M.D. 51705 10-01-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANS URIYA 349 Malwim DR Westminster, MD 21157 31. Date filed (Month, Day, Year) State 2010 OCT

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ LAWKINS 29 9:20A M MACION 2010 Medical 4a. Facility Name (if not institution, give street and number County of Death Examiner 4b. City, Town, or Location of Death YACK Brandywine Floral If Under 1 Year | FUnder 24 Hrs Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (9 te or Foreian **Funeral** 1 □ M 2 🗗 F (Month, Day, Year Months MARTIO Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MARYANA T 10e. Street and Number Srandywine 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20613 -10m 6801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕻 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed SACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) omestic tonemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F WALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 129 20613 Arvin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 10-2-10 4 Dogation 5 Other (Specify) 21. Signature of Funeral Service 7.0608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hotav. Iscla DI Long Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce D3(206 Septenter 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) For MARKING for Mary/and 3015 11761 Tonne my 32 Registrar's Signature 31. Date filed (f

Registrar

Maryland 21215-0036

Baltimore.

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32425 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 28 2010 1:42 A. M Edgar Hinton September James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Country)
Indiana 1 X M 2 □ F Months Days Hours May 9. 1922 88 Director 305-14-3916 Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 786 Kimberly Court West 20878 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 X Yes 2 No 1942-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced 1946 Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumasic. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Fyffe 0scar Hinton Haze1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13904 Riding Loop Drive, Gaithersburg, MD. 20878 Janice M. Hinton/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/28/2010 Alexandria, Virginia Metropolitan Crem. ature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cardiac Physician/ minutes disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner potension hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): hours To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial transit Blecdino that initiated events resulting in death) Last Due to (or as a consequence of): hours Coaque path Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ဂ္ 1 Inpatient 2 ER/Outpatient 3 II DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) G258C +1

State

Registrar

Medical

Center Drive, Rockyille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hurosh

(Month, Day, Year)

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Registrar's Signa

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Frances Toby Illowsky September 7:51 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 X F Hours Min. New York Director 213-26-1836 1/26/1920 89 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director tx☐ Yes 2 ☐ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 251 Congressional Lane #109 20852 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Teacher High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Max Hersh Leah Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Illowsky Karp, daughter 12007 Smoketree Road, Potomac, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Mt. Lebanon Cemetery 09/27/2010 Iselin, New Jersey 4 Donation 5 Other (Specify) 21. Signature of Laneral Sourice Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. MO1255 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burialattending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 🗌 Yes Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🙀 No မှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 1 🔣 Natural 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month. Day, Year) D4023 September 28, 2010

Registrar
DHMH 17 Rev 7/2009

State

5530 Wisconsin Avenue, Chevy Chase, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

William Battle, MD,

29

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 1,24a per dr., g908,10/15/2010dhb Certificate of Death Reg. No. Reg. No.-1. Decedent's Name (First, Middle, Last) Geneva M. 2. Date of Death Jaeger Year **Physician** GENEVA JAEGER TARCH 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign CENTER Date of Birth (Month, Day, Year) 1-10-1927 7. Age (In yrs. last birthday) If Under I Year | If Unde Sex 1 □ M 2 □ F **Funeral** Months Days Hours Min. Pennsylvania Director 190201779 83 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County ms 23a or 28a-f show 1 XYes 2 No Director Charles MD Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4673 Grosbeak Place 20603 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 27 is marked other than "natural", or iter r trau⊓atic event, the Weden Evander 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 ∐WNo Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Typesetter Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Martinus Jespersen Marie Larsen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4673 Grosbeak Pl. Waldorf, MD Rhonda Simard Daughter Department of Health Important: If item 27 an Anjury or other tonce. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 3-29-2010 Hyattsville, Mp 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd, Waldorf, MD 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respirator disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical λvO. IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D. Habyn D0069154 03/24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Civista Medical Center

State Registrar Habtgiorgis,

MAR 2 5 2010

31. Date filed (Month, Day, Year)

Avenue,

La

Plata,

Garrett

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** WILLIAM T. **JOINER OCTOBER** 5 2010 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chestertown Nursing & Rehab Chestertown 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2□ F 215-20-0403 87 Director Jan 16 1923 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Director Kent Worton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Itams 23a or 25935 Worton Lynch Rd. 21678 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 12 Transportation permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 Is markad oth eny lijury or other traumatic evant ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Henry Joiner Rachel Marie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Joiner, Jr. (brother) 25935 Worton Lynch Rd. Worton, MD. 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 10/7/10 Kent Cremation *4 Donation 5 Dother (Specify) > Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech 21. Signatura of Fineral Service Licensee M00510 118 West Cross St. Galena, MD. 21635

Rad Enter/he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Reno Priysician MYDUIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit or Attending Physicien: The law requires that the death certificate be executed Box 68760' Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Tlinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DMTGDe 2; HxCVAiBPHCOGStruction 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 280 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ours after death.

nerel Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) D0050916 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard M.D. 100 Brown St . Chestertown, MD. 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 152010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Herman Aldolphus Leedy 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Williamsport Washington County 16815 Hampton Rd. 8. Date of Birth Month, Day Yea March 20 9. Birthplace (State or Foreign Country) 1913 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F Months Hours 214-09-3175 97 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland Washington County Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 U.S.A. 16815 Hampton Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Mfg. Lead Man Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Clinton Leedy Lettie Virginia Pittinger Leedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16815 Hampton Rd. Williamsport, MD 21795 Florence E. Leedy-wife 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10-7-2010 Smithsburg, 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses a 1331 Eastern Blvd. North Hagerstown. 21742 23a. Part 1. Enter the disease Secomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclessa disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 5 Other (specify) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

> and burial-trar

the attending physician

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been signed by the atter should be detached for u

page 2 should

has

within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director,

To the Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

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Director

Funeral

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Physician/Medical

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the Medical Examiner must be notified at

"natural", or items 23a or

al Hygiene. I other than "

of Health and Mental Hygie If item 27 is marked other or other traumatic event, the

permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

> Natural Accident

Suicide

31. Date filed (Month, Day, Year)

OCT

4 Homicide

1 \square Yes 24a. Was an

2 No 3 ☐ Probably 4 ☐ Unknown

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to predical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of

5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28f. Location (Street and Number or Rural Route Number, City or Town, State,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29d. Date signed (Month, Day, Year) and title

death (Item 23a) (Type. cause

5 Pending

Investigation

determined

6 Could not be

13H-4 State

> Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#10c.&10f.perfuneralhoment/fice/te/or/Coentbb 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Monthee 12158 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WK Adventi acoma Montgoiner 9. Birthplace Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** State or Foreign Months Min. Watshing by Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Suitland 10d. Inside City Limits Director 1 Yes 2 No Marzyland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3804 20746 12. Was Decedent Ever in Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natura!". 3 Divorced Completed Black Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) omestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 10-1-10 21. Si natur of Funeral Service Lice 22. Name and Address of Facility MI 2060 8 MOIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a enace of) resulting in death) Last Physician/Medical phys the b Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page encenka 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation М the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c/License number Titem 23a) (Type 10021 Maks 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28, 2010 2010 12:20 a M Wah Ting Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice-Casey House Derwood Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month Day Year)

Dec. 3, 1952 Birthplace (State or Foreign Country) **Funeral** 1 🖾 M 2 🗆 F Days Hours **Director** 579-72-8733 57 Yrs. China Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Gaithersburg MD Montgomery 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral 14520 Settlers Landing Way 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Victory Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian Year or Dates. Vietnam "natural", 3 Widowed 4 Divorced Completed nd Mental Hygiene. marked other than "natur imatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Naval Surface Warfare Ctr.-Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Carderock Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ngin Hong Lee Mei King Tam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14520 Settlers Landing Way, Gaithersburg, MD 20878 Eileen Darlih Sun Lee/Wife other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 permit. Page 1
Department of 1
Important: If it
any injury or o
once. cemetery, crematory or other place) Oct. 1 ★ Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, MD 21. Signature Funeral Service Censee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spri Kuhard X Males Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Liver Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or impury that initiated events resulting in death) Last burial-transit that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy p in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 w No death? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 4 Nursing Home 5 Residence 6 v Other မ 1 Inpatient 2 ER/Outpatient 3 DOA pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖪 Natural 5 Pending 24 hours after death.

Funeral Director: A 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the I

comple only one) 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

204

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1355 Piccard Drive, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicole Christensen, CRNP

R120698

Sept. 28, 2010

			State of Maryland / Dep	artment of Health and Martificate of Death	lental Hyg	iene2010	32433
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate or Death	2. Date of Deat	eg. No.	3. Time of Death
	Physicia		Donna Marie Lewis		Month Sept	Day 2010	7:55 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-			Casey House	Rockville		Montgome	-
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 M 2 1 F 58 Yrs. 58 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept.	Year) 9. Birth Cou.	place (State or Foreign ntry) nington, DC
, A			Usual Residence of Decedent		ъерг	+, 1954 was	ining con, DC
	f sho	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Man 28a- otifie	Director	MD Montgomery Gaithers 10e. Street and Number				1 X Yes 2 ☐ No
	ith the	ral [101 Odendhal Ave #115	10f. Zip Code 20877		0g. Citizen of What Cou	
	ems 2	Funeral		Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	nited State	
٥	or it	by F	Armed Forces? 1 ☒ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
215-0036	urs af tural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: W	11100
ζ	72 ho n "na"	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation I kind of work done during most of worki OO NOT use retired)	ng	16b. Kind of Business In	ndustry
717	filed within 72 hours after death with the Maryland at Hygiene 19. Hygiene 19. Hygiene 19. Weet, than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1-4 or 5+)	min. Assistant		Hospital:	ity
ğ	be filed vental Hyg rked othe ic event,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		· · · · · · · · · · · · · · · · · · ·	
yla	should be file n and Mental 7 is marked o raumatic eve	욘	Sydney Lewis	Mary An	n Spirko)	
Baltimore, Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene, a strain and the strain and the strain and the strain and the strain and the strain and the strain and the notified at other traumatic event, the Medical Examiner must be notified at			ing Address (Street and Number or Rura ridle Court, Potom			Code)
<u>6</u>	e 1 and 2 s of Health of Item 27 if item 27 ir		20a. Method of Disposition 20b. Place of Disp	osition (Name of		20c. Location - City or T	own, State
Ē	Page nent or int: If ry or			nnatory or other place) In Crematory 10/01	1/2010	Brentwood,	Maryland
alti	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee M01463	2. Name and Address of Facility	imple Tr	ibute	
n	9 Q T P 9		relias	1040 Rockville Pik			0853
			23a. Part 1. Efter the disease, or complications that caused the death. Do not en shock, or leart fallere. List only one cause on each line. Immediate (a.se (Fire)		r respiratory arre	st,	Approximate Interval Between Onset and Death
	nysician/ Medical		disease or c dition resulting in death) Lung Cand Due to (or as a consequence of):	er			Silot and Badan
	Examiner						
	T *1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	and	xan	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):				
-	ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial the particular than the particular	cal	d				
08/00	ficate g phy as the	Physician/Medical		<u> </u>			
š ×	h certi tendin r use	an/l	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1			23d. Date of deliv	
Pox	e deat the att hed fo	ysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		Month	Day Year
7. Ö	ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
s,	uires t n sign Ild be	ed by			1 □ Ye	es 2 □ No 3 □ Pro	bably 4 🛣 Unknown
Š 5	w required is bee	plet			24a. Was ar autops		ppsy findings available empletion of cause of
Vital Records,	The la ate ha page	Completed			perform	ned? death?	.
Ę	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check			
01	Physi this cral dir	2	1 Yes 2 No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of Death	ent 3 ☐ DOA ☐ 4 ☐ Nursing Ho		nce 6 🗷 Other (Specification of the control of the	y) Hospice
סב	nding ath. : After e fune	cate	1 Natural 5 □ Pending (Month, Day, Year) injury Accident Investigation	work? M 1 □ Yes 2 □ No	Edd. Describe (10	w injury occurred	
DIVISION	r Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Str	reet and Number or Rura	l Route Number,
5	oital o urs af ral Di						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time, date and	d place, and due to the ca	ause(s) and manner stated.
	To the within To the Comp	2	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,	
	Q		Dine Kuckert Carp	R115108		9/25/	10
			30. Name and address of person who completed cause of death (Item 23a) (Type,		D 1 P 1		20055
	Stat	te	Diane Ruckert CRNP, Casey House 6 31. Date filed (MSE Pay, Xaa) 2010 32 Registrar's Signature	ooi Muncaster Mill	ка Кос	kville, MD	20855
	Registra	ar	SEP 29 2010 Cerus A. So	also			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANGELO SABATO LAMBERTI 0047 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Memoria =aston albo . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Davs Hours Min oct. 5, 1936 NEW YORK 058-28-2230 73 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector notified 28a-f 1 Tes 2 No WYE MILLS TALBOT MD ۵ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or Funeral 21679 28768 DOLVIN CIRCLE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Year or Dates.1954–1958 WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) U.S. POSTAL SERVICE LETTER CARRIER 11 and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 VIRGINIA BARONE SABATO LAMBERTI Angeli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 28768 DOLVIN CIRCLE, WYE MILLS, MD 21679 JUDITH LAMBERTI/ WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State OCT.1,2010 HURLOCK, MARYLAND MD VETERAN CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subduzal Hunaloma Physician arge Medical resulting in death) Due to (as a consequence of): humorrhage with herniation Examiner stem ram Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): pagulopath' Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (as a consequence of): (attending physician Physician/Medical per tension the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) hed f 9 Unknown signed by ti P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 2 No 3 Probably 4 Unknown Records, 1 Yes fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsv performed Yes 2 1 Yes 2 No certificate 25. Was case referred to medical examiner? Vital 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA this Division of funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mohan D0069567 Sept, 28, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP 29

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RAVI MOHAN, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October ARTHUR FRANKLIN LEAGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fostor a If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **⊠** M 2 □ F Days JUNE, Pro Mary land 53 °1957 Director 216-64-9066 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Kent Still Pond 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26641 Maple Ave. 21667 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 11 Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Roland Leager Jean Ann Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Ann Leager (mother) 26120 Bessicks Corner Rd. Still Pond, MD. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Still Pond Cemetery 10/9/10 Still Pond, MD. 4 Donation 5 Other (Specify) Juneral Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ sivator 0 Medical resulting in death) Due to (or as a conseque of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last as been signed by the attending physician 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) Live Birth 2 L retail 2 in the past 12 months? Month Day Vear 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate ! 2 🗌 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director, Hospital: 2 **X**No Other: 1 Yes |2 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Acciden injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Director: Af Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 W.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician/ William . Russell October Lark 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Dec 24, I 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1**X** M 2 □ F Months Maryland Dec. 1949 60 Director 218-50-4509 Usual Residence of Decedent or 28a-f shov Director 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 1
▼ Yes 2 □ No MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21740 U.S.A. 55 Nottingham Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Welder Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ပ Mary Catherine Sager Roy Thomas Lark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham Rd., Hagerstown, MD 21740 <u>Virginia</u> A. Lark/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10/5/2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO PULMONARY ARREST Ph_sician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ACTTE ET PIRATORY Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying WRYNGEAL CANCER attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical TIBRILLATION WITH RAPID VENTRICULAR Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnam Unknown 5 Other (specify) Pregnant at time of death the page 2 should be detached signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 1 No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Hospital 2 No 1 Tyes ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 🛱 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 5 \square Pending 1 Pr Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66892 10/04 MOHAMMED A212

Registrar
DHMH 17 Rev 7/2009

State

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antietamSt. Hagerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Mohamed
31. Datě filed (Month, Day, Year)

1 5 2010

			For State	State of Ma	aryland /				and M	ental Hyg	giene	010	32437
		_	Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate of I	Death			Reg. No-	010	1
п	Physicia		Judith Eliza	both	Mula					2. Date of Dea Month		2010 Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give stre		Mula		4b. City, Town, c	r Location o	of Death	Octobe		Dunty of Death	1:55 a. M
-	f		St. Mary's Nursir	g Center	•			ardto				St. Man	_
	Funeral		St. Mary's Nursin 5. Social Security Number 6. Sex	7. Age			If Under 1 Year Months Days		24 Hrs.	8. Date of Birth	1		place (State or Foreign
	Director		552-58-9603	VIZLALF	67	Yrs.	Months Buye	, nouro		07/27/1	943	Ariz	
	and show	ē	10a. State 10b. County		10c. City, Tow	vn or Loc	cation						10d. Inside City Limits
	Maryla 28a-f atifiec	Director	Maryland St. Mary's		Leonai	cdto	wn						1 🗌 Yes 2 🕱 No
	a or a		10e. Street and Number				10f. Zip Code				10 <i>g</i> . Citizer	n of What Cou	intry?
	th witi ms 23 must	Funeral	22545 Calvert Stre				20650				Unite	ed Stat	es
	r deat		11. Marital Status 12 1 Never Married 2 Married	. Was Decedent E Armed Forces?			Vas Decedent of H Yes, specify Cubi				14.	Race - Americ Black, White,	
036	safte ral", o Exan	ed by	3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.	INO	1	☐ Yes 2 ☐ XNo	Specify:			Spe	ecify: Wh	ite
2-0	hour hatu dical	Completed	15. Decedent's Educi (Specify only highest grade	ation	168		ent's Usual Occup		of workin		16b. Kind	of Business In	
21	hin 72 ne. than the lee Me	E O	Elementary/Seconday (0-12)	College (1-4 or 5		life. DO	ONOT use retired)	duning most	OFWORKI	9			
2	ed wit Hygie other	Be	17. Father's Name (First, Middle, Last)	4	Hc	omema	aker	10 Maths	rio Mama	(First, Middle, I	Own H		
Maryland 21215-0036	be fille ental ked c	횬	Ernest Edward Wint	erc						Wadde]		iarrie)	
ary	hould and M s mai		19a. Informant's Name/Relationship (Type,		19	b. Mailin	g Address (Street		_			vn, State, Zip	Code)
Σ	nd 2 sealth an 27 in		Jodi Barsness/Daug	hter	Ρ.	0.	Box 1804	Leor	nardt	own, MI	206	550	
ore	ge 1 au t of H Hitel oroth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State			sition (Name of atory or other plac	ce)	Da	ate	20c. Locat	tion - City or To	own, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)		Brinsf		i-Echols						
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licenses Danielle Ward M	101403	loca		Name and Addre 2955 Ho1						-
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of			not ente	r the mode of dyir	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Conor	estive	Hec	et lail	ure.					Onset and Death
- negotia	Examiner		resoluting in dealing	Due to (or se a	consequence	,	malu (0 1000	. di	N2A ACN			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	4.0	on any	WATEN	y ac	NONE.			
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Hypod	thyes	dus	m						
	e exectian ar	E E	resulting in death) Last	Due to for as a			\cap						
09	cate be executed physician and the burial-transit	dical	d.	Dimi	etesty	126	d						 =
687	eath certifica attending ph for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome o	of pregnancy						00-1	Data of data	
P.O. Box 687	eath c atten d for u	Physician/Me	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at	2 🗌 Fetal deat		Ectopic pregnand Other (specify)	су		- Constant	230	I. Date of deliv Month	Day Year
П	the d by the achec	hys	9 ∐ Unknown	9 Unknown									
9.	es that the dea signed by the a I be detached f	by	Part II. Other significant conditions contri	buting to death bu	ut not resulting	in the ur	nderlying cause gi	ven in Part I	•		/	ontribute to the	he cause of death?
rds	require been si should b	eted								1 🗆 Y	es 2 📈 N	√lo 3 ∐ Pro	bably 4 Unknown
Division of Vital Records,	The law rate has b	Completed								24a. Was a autops perform	med?	4b. Were auto prior to co death? 1 Yes	psy findings available empletion of cause of
alF	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Pl	ace of Deat	M'(Check o	1 \(\text{Yes} \)	2,E_1 NO]	I L Yes	2 L NO
Ξ	Physic this ce al dire	욘	1 ☐ Yes 2 Ø No	1 U Inpatie	nt 2 ER/O	_		4 ∠ Nu	rsing Hom	ne 5 Reside	ence 6 🗆	Other (Specify	0
n of	ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,	Year) 28b.	Time of injury	28c. Injur work	y at (? Yes 2 🗌		Bd. Describe ho	w injury occ	curred	
siol	Attendi r death ctor: A y the fi	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	ry - At home, fa	arm, stre		res 2 🗆	-	Bf. Location (St	reet and Nu	imber or Rura	I Route Number,
DΖ	al or safter		4 ☐ Homicide determined	building, etc.						City or Town		moor or mara	riodic ridingo,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check one)	On the basis of ex-	amination and/	or investi	gation, in my opinio	on, death oc	curred at the	he time, date an	d place, and	d due to the car	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier				29c. License		~ ~			gned (Month,	
			> huardeep ka	lug .			D00	0/09	00		10	105/10	0
dh	,		30. Name and address of person who comp 2007 Tidewover Cr	oleted cause of de	^	(Type, Pr	4 m A	nnapa	olis	mD	2140) l	
	Stat Registra		31. Date filed (Month, Day, Year) OCT 0 5 2010	37. Registrar	's Signature	ha	w						
		Registrar OCT 0 5 2010 Centur B. Sparks											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 27, 2010 2040 McKenna Georgia 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign ^{Year} 1944 1 □ M 2 🛣 F Months Days Hours Massachusetts 471-08-3493 66 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2612 29th Street #2, SE 20020 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. 1 🛣 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Social Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) George McKenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Harvard Street, NW Louise Green/Pastor Washington, DC 20009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial ② Cremation 3 ☐ Removal from State Final Journey Crematory 10/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland re of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. MD 21029 Clarksville, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician/ Medical Examiner

Department of Important: If it any injury or or once.

Physician/

Medical

10a. State

DC

Examiner

Funeral

Director

or 28a-f show e notified at

Director

Funeral

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Completed

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-trans the attending physician and within 24 hours after death.

To the Funeral Director: After this certificate has been signed by t completed filled in by the funeral director, page 2 should be detact

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition	Metastatic L	ung Ca	ncer				Onset and Death	
	resulting in death)	Due to (or as a consequence of	of):						
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a consequence of	of):						_
dical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of	of):						
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		pic pregnancy er (specify)		_	23d. Date of de Month	elivery Day Year	
	Part II. Other significant conditions c	ontributing to death but not resulting in	n the underly	ing cause given in Part I.				o the cause of death? Probably 4 XUnknown	
Completed					pe	as an atopsy erformed?	death?	itopsy findings available completion of cause of	
Be (25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)				Π
To	1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatient 2 ☐ ER/Ou	tpatient 3	DOA Other:	lome 5 🗆 Re	esidence	6 ☐ Other (Spec	cifv)	
ficate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	1	ime of njury M	28c. Injury at work?	28d. Describ				
Medical Certificate:	3 Suicide 6 Could not b	e 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, fa	ctory, office		n (Street ar Town, State		ral Route Number,	
Medica	(Check 2 Medical Exami	sician: To the best of my knowledge, of iner: On the basis of examination and/o se Practioner: To the best of my knowless.	r investigation	n, in my opinion, death occurred a	at the time, dat	te and plac	e, and due to the	cause(s) and manner stated	d.
	29b. Signature and title of certifier			29c. License number		29d. Da	ate signed (Monti	h, Day, Year)	
	1 019 6	tel Jayanti		1)005258	6		1/28/10	C	

1,500 Forest Glen Road Silver Spring, Maryland 20910

9/28/10

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

necul

Jayanti L. Patel

OCI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Catherine M Machinas Sept 26. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Country) 1 M 2 174 38 5558 63 Jan Penn Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 XX No Maryland 1 Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral United States 7011 Virsmanco Lane 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 4t Registered Nurse Health Care Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Joseph Machinas Valentina Geguvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Von Stitt (son) 12844 Claxton Drive, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Lee Crematory Clinton, Maryland October 5, 2010 Other (Specify) 22. Name and Address of Facility Funeral Home, inc 6633 Old Alexandria Service icenses 21. Signatur Ferry Road, Clinton, MD 20735 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final disease or condition resulting in death) or heart failure. List only one cause on each line. Land.L A SJINe Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ atter in the past 12 months?

1 Yes 2 No Month Day Year ģ Pregnant at time of death the 9 Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed Yes 2 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number

State Registrar 31. Date filed (Month, Day, Year)

ULIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar 32440 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 **Physician** 2010 25 NEAL STEWART McCOY 10:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4312 HOLLY HARBOR ROAD OXFORD TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Director 69 510-42-4593 11/22/1940 KANSAS Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Evaminar must be notified at Director 1 ☐Yes 2 ▼ No MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4312 HOLLY HARBOR ROAD Funeral 21654 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ð Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) CORPORATE AND Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, ITM Once. **SECURITIES** ATTORNEY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be R. STEWART McCOY ALMA E. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE_C. McCOY - WIFE 4312 HOLLY HARBOR ROAD, OXFORD, MD 21654 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 09/29/2010 OXFORD, MD OXFORD CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 JOHN MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic esophageal **Physician** cancer Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner day, leaving to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Due to (or as a consequence of): physician a the burial-Box 68760. attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? Month Year Day o. been signed by the should be detached 1 Tyes 2 No. 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by poliomyeli Childhood 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 🗷 No 1 □Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

commoletely filled in by the fur 1.XNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Vaio MD DO57749 Lakshmi SEPTEMBER 27 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAIDYANATHAN 219 S. WASHINGTON ST, EASTON, MD 21601 LAKSHMI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 27 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 28,2010 Physician/ September 00:08A Church Morgan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PG Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 3/27/1922 Days 1**火** M 2 □ F Min. Hours 88 Director 225-20-3784 Virginia Usual Residence of Decedent or 28a-f show notified at ige 1 and 2 should be filed within 72 hours after death with the Maryland and Peatht and Mental Hygiene.

t: If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Temple Hills PG 1X Yes 2 ☐ No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3919 Triton Court 20748 USA . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: Black Year or Dates. 43-46 3√XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Engineerer Federal Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lizer Moton Lewis Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangeline Morgan/Daughter 3919 Triton Court; Temple Hills, MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Department or Important: If any injury or Maryland Vet. Cem. 10/04/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) re f Fune al Service Litense 22. Name and Address of Facility Raymond & Wood F. H./ P.A. P.O. Box 430; Dunkirk, Maryland 20754 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final S EPSIS Physician/ disease or condition resulting in death) Medical **Examiner** INFECTION URINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC LIDNEY DISEASE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one

State Registrar 29b. Signature and title of

MD

.Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

200 64 986

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 1 3 2 4 4 2 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certi	ficate of L	Death		R	leg. No.			
Physic		Decedent's Name (First, Middle,Last)					2. Date of Dea	ath			3. Time of Death
Medical Exam	iner	Lora Ann	Alegria Monta	gue			Month September	Day er 24,	2010 Year		2231 hrs
		4a. Facility Name (if not institution, give s	treet and number)	4b	City, Town, o	r Location of Dea	th	40	. County o	f Death	
		Holy Cross Hospital			Silver Sprin	ng		١	Montgom	nery	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Yea	ar If Under 24H	s. 8. Date of Bi	rth (MM/	(DD/YYYY)	9. Birth	place (State or
Director		577-88-4794 1 M	2 X F 46	Yrs.	Months Day	ys Hours Mi	n. Februa	ıry .	964 5,	Cou	Washington D.C.
>		Usual Residence of Decedent									
w an		10a. State 10b. County		own or Location	1						10d. Inside City Limits
land f sho	ō	District of Columb	oia	Washin	gton						1 X Yes 2 No
Mary 28a-	Director	10e, Street and Number			10f. Zip Code		1	0g. Citi	zen of Wha	at Count	λ.
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Marulal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ö	506 Allison Stre			200				ited	Sta	tes
th wi	Funeral	11. Marital Status 1 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?	13. Was I If Yes	Decedent of Hi specify Cuba	spanic Origin? (§ n, Mexican, Puert	specify Yes or No o Rican, etc.))-	14. Race - White,		an Indian, Black,
er dez , or ii	Ŀ		Yes 2 X No	1,				ŀ		D.1	
rs aft ural" mine	by	3 Widowed 4 Divorced If 15. Decedent's Education (Specify only	Dates:			specify: ition (Give kind of	al. dana	1	Specify: Kind of Bus		
hou "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most	of working life	DO NOT use re	tired)	IOD. P	VING OF BUS	mess/inc	dustry
36 hin 72 e. than dical	ple		years	Regist	ered N	ITCA		Dr	ovide	nco	Hospital
-00 d with	ю	17. Father's Name (First, Middle, Last)	yearo	Regise	CICU N	18.Mother's Nam	e (First Middle I			псе	повртсат
e files al Hysiced o	Be C	Alfonso Alegri	а				lascoe J				
212 uld b Meni mark	To E	19a. Informant's Name/Relationship (Type		19b. Mailing A	ddress (Stree	et and Number or				State 2	Zip Code)
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than sumatic event, the Medica	_	Reba G. Alegria (M	lother)			Street,N					
e, N and Health item trau		20a. Method of Disposition	20b. Pla	ce of Disposition	n (Name of ce	metery,	Date	20c, L	Location - 0	City or To	own, State
OF ges 1 it of 1 it If		1 X Burial 2 Cremation 3	Removal IIom State	matory or other		0c	t.5,2010	·			
Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tr		Donation 5 Other Specify: Signature of Funeral Service Licensee		int Oli	vet Cen	netery	N TY -	Was	shing	ton,	D.C.
Ba perm Depa Impo injur		21. digrature of rufferal Service Licensee	10.11/	`					-	_	forticians,
Physician		23a. Part I. Enter the disease, or complica	tions that caused the death. Do	not enter the	node of dving	such as cardiac	r respiratory arr	est sho	Wash1	ngto	Approximate Interval
/Medical		failure. List only one cause on each	line.		,		, , , , , , , , , , , , , , , , , , , ,	,		`	Between Onset and Death
Examiner			rdiac Arrhythmia e to (or as a consequence of):						_		Death
		⊾ Ca	rdiac Hypertrophy								
	ē		to (or as a consequence of):				-				
	Ē	cause, Enter Underlying Cause (Disease or injury that initiated	1-1-1-1								
ecuted and transit	Examiner	events resulting in death) Last d.	e to (or as a consequence of):							- 1	
ਿਤਾਡੀ G	/Medical		MENDED								
760, Icate be exe g physician a	Neo	IF FEMALE:	23c. If yes, outcome of pregnan	CV				23d	. Date of de	elivery	
387 rrific ling p		23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal	death 3	Ectopic pregn	ancy		Month	Day	/ Year
Box 68 death certifi the attending ed for use as	Physiciar	1 Yes 2 Als 2 Ustraus 1	Pregnant at time of death	5 Other	(Specify)			-			
B G G G G G G G G G G G G G G G G G G G	چ		Unknown								
P.O. es that the igned by	by F	Part II. Other significant conditions con	ntributing to death but not resul	Iting in the unde	erlying cause o	jiven in Part I.					e cause of death?
S, F uires I n sign d be		Graves Disease							No 3	Probab	oly 4 Unknown
ords w requir	let let						24a. Was a autop:				sy findings available pletion of cause of
Reco The laricate ha	Completed						perfor 1 ✓ Yes 2		dea	ath? Yes	2 No
tal Re ian: The certificate ector, page	σl	25. Was case referred to medical			26.Place	of Death (Check					2
Vital hysician: this certifi I director,	O B	examiner? 1 ✓ Yes 2 No	ital: 1	/Outpatient 3	DOA	Other Nursin	ng Home 5 I	Resider	nce 6	Other:	
Division of Vital Records, is to Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death	28a. Date of Injury 28 (Month, Day, Year)	b. Time of Injur	y 28c. Injur	y at Work?	28d. Describe h	ow injur	ry occurred	ı	
ion of tending Pheath.	흹	1 Natural 5 Pending	(Month, Day, real)		1 1	es 2 No					
r Att	길	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	, farm, street, fa	actory, office b	uilding, etc.	28f. Location (S	treet an	nd Number	or Rural	Route Number, City
Divis pital or At ours after d eral Direct filled in by	Certification:	4 Homicide determined	(Specify)				or Town, St	ate)			
Divisior Hospital or Attene 24 hours after death Funeral Director:		29a Certifier	To the best of my knowledge, of	death occurred	at the time, da	ite and place, and	due to the cause	e(s) and	manner as	s stated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On	the basis of examination and/o	or investigation,	in my opinion	, death occurred a	t the time, date a	and plac	e, and due	to the c	ause(s)
E 3 E S	Me	29b Signature and title of certifier			29c. License	e number		29d. D	ate signed	(Month	. Day, Year)
		Va. Londo all			O.C.N	И.E.		Sept	ember 2	5, 201	0
_	ŀ	30. Name and address of person who com	pleted cause of death (Item 23a	a)							
				•	reet, Baltin	nore, MD 212	01				
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur					-			
Regist		OCT 0 4 2010 🕰	ever D. DA	West .							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 28 2010 e otembe Betty Jeanne Mills 0915 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Hours Gormania, WV Days IO. Director 578-34-1261 86 Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Crofton 1 X Yes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2364 Putnam Lane 21114 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ρ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give White 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that College (1-4 or 5+) Secretary DC Health Department 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert J. Foley (Unav.) Mvrtle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory A. Mills / Son 2364 Putnam Lane, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or 10/4/2010 Rockville, Maryland Parklawn Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue cans Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed Or ONUTY OF TO Due to (or as a consequence of): attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2. No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown the detached Unknown Division of Vital Records, P.O. à cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 2 🗌 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\bar{\mathbb{K}} \) No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) nowen Drive Elkridge Maryland 21075

DHMH 17 Rev 7/2009

State Registrar

			For State Registrar	State of	Maryland / I	-	rtment of		and M		giene	0 1 0	32444
	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	eath Da	y Year	3. Time of Death
P. A. Spirit	/Medio		CYNTHIA 4a. Facility Name (If not institution,	give street and numb	MILLER per)		4b. City, Town,	or Location		SEPTEM		28 2010 County of Deat	12:27 PM
			ANNE ARUNDEL				ANNAP					NNE ARUI	NDEL
	Funeral Director		5. Social Security Number 6 577-70-8952	1. Sex 1 □ M 2 1 □ F	Age (In yrs. last bit	rthday) _ Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da AUG. 2	av. Year)	Co	hplace (State or Foreign untry) HINGTON, DC
	· ·		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Tow	m or los				1100. 2		TOOL WILL	
	Maryla -f sho	ţō		GEORGE'S	BOWII		allon						10d. Inside City Limits 1 Yes 2 No
	or 28a	Director	10e. Street and Number	CLORGE D	DOWLI		10f. Zip Code				10g. Cit	izen of What Co	untry?
	sath w	eral	3205 ALYSHBA CO		-15	40.14		0721	0 /0		USA		
036	urs after de al'', or item	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	12. Was Deceded Armed Force 1 □ Yes 2 If Yes, Give Year or Date	es? M∭No		/as Decedent of Yes, specify Cul ☐Yes 2 ☑ No		gin? (Spe n, Puerto P	city Yes or No Rican, etc.))-	14. Race - Ame Black, White Specify: B	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Eventher must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4		(Give k. life. Di	ent's Usual Occu ind of work done O NOT use retire	during mos	t of workin	g		ind of Business/I	,
ر م	filed w I Hygie other t ent, th	a	17. Father's Name (First, Middle, La	5yrs		LA	WYER	18. Mothe	er's Name	(First, Middle			VERNMENT
ylan	should be filed withir and Mental Hygiene. s marked other than umatic event, tra M	To B	ERVING MILLER					D	OROTI	Y NOIS	SETTE	Ξ	
Maryland	short and and and and and and and and and and		19a. Informant's Name/Relationship			-						or Town, State, Z	ip Code)
	s 1 and of Heali Item 2		THERESA BRYANT / 20a. Method of Disposition		20b. Place of	f Disposi	KEPMER (ition (Name of	; -		M, MARY		20706 ocation - City or 1	
altimore,	Page ment c ant: If ury or		1 □ Mourial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				atory`or other pla LN CEME		10-2-	-2010	BREN	NTWOOD,M	ARYLAND
Ball	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Lic	Callo	van								AND 20785
	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	emplications that causely one cause on each	1			ing, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or	as a consequente								Years
	Examiner	e.	Sequentially list conditions,	b Due to (or	as a consequence	ofi:							
	ecuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Unisease or injury that initiated events	c		/-							
8760,	icate be executed physician and the burial-transit	ä. Ex	resulting in death) Last	Due to (or	as a consequence	of):							
9		/ledica/		d									
O. Box	the death certific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ☐ Fetal death it at time of death		Ectopic pregnan Other (specify) _	су				23d. Date of deli Month	very Day Year
., J.	s that t gned by e detac	by Ph	Part II. Other significant conditions	contributing to death	n but not resulting in	n the und	derlying cause gi	ven in Part I.		23e. Did to	obacco u	use contribute to	the cause of death?
org	requires that een signed b nould be deta									10	Yes 2	No 3□ Pro	bably 4 🗌 Unknown
ľ	The law ate has b page 2 st	Completed										prior to c death?	opsy findings available ompletion of cause of 2 점 No
VITAL	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	atient 2 ☐ ER/Ou	utnationt.	3 DOA Oti			(Check only o		6 □Other (Spec	W.A.
o u	ing Phys After this Ineral dii	On: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I	njury 28b. 7	Time of njury	28c. Inju			Bd. Describe I			iry)
DIVISION	Attendideath.	ficati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	ho -	Injury - At home far	rm stree]Yes 2□N		of Location (Stroot an	d Number or Du	ral Route Number,
2	tal or / rs after al Dire ed in b	Certification:	4 ☐ Homicide determine	building,	Injury - At home, fai etc. <i>(Specify)</i>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, (4010),, 01100			City or Tov			ar noute warmber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examination an	e, death o	occurred at the t estigation, in my	ime, date an opinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) date and) and manner as I place, and due	stated. to the cause(s)
	Vith vith Com	Σ	29b. Signature and title of contifier	1 Bella	Mus		29c. Licens	se number) _		29d. Dat	te signed (Month	
^	6		30. Name and address of person who	o completed cause o	f death (Item 23a) ((Type Pr	rint)	^		0 '	`	LIVOIN	
_	5		Stoerd Beck, 31. Date filed (Month, Day, Year)	HUD 200	1 Wedica	d Vo	nkway	Much	o ha	un, ru	Ø		
	Stat Registra		31. Date filed (Month, Day, Year) OCT 0 4 2010	General)	figure signature	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 32445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201o Earle Edward Moyer, Jr 2120 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 100 Greenway, Apartment 403 Ceci1 Perryville 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. **Funeral** If Under 1 Year 9. Birthplace (State or Foreign Days Hours Director 169-20-4365 Pennsylvania 83 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Ceci1 1 X Yes 2 No Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Greenway, Apartment 403 21903 United States 12. Was Decedent Ever in U.S.
Armed Forces? World
1 X Yes 2 \(\subseteq \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. War II 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Management Water and Sewer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Earle E. Moyer Mary Acheson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Moyer/Wife 100 Greenway, Apartment 403, Perryville, MD 21903 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Garrison Forest
Veterans Cemetery 4 Donation 5 Other (Specify) 14, 2010 Owings Mills, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signative of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 05 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s has autonsy certificate ☐ Yes 1 🗀 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗙 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work's death. 1 Tes Accident 2 🗆 No Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d/title of certifie 29b. Signature an 29d. Date signed (Month) Dav. Year) 36-Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 32446 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florence Margaret Nusz October 2010 10:45 Medical A M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Frederick 8905 Yellow Springs Road Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min. September 26, 1920 213-16-1972 90 Director Maryland Usual Residence of Decedent 28a-f shov 10a State 10h County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland Frederick Frederick 1 🗌 Yes 2 🛣 No 9 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be r 10g. Citizen of What Country? Funeral 8905 Yellow Springs Road 21702 United States of America death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, be filed within 72 hours after de antal Hygiene. ked other than "natural", or it c event, the Medical Examine Armed Force þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Midowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ဂ Harvey Wills Nellie Mae Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Remsberg / Daughter 8905 Yellow Springs Road, Frederick, Maryland 21702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Smithsburg Crematory October 8, 2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Months Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter onderlying Cause (Disease or linjury Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 🏝 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy After this certificate by funeral director, page performe Yes 2 X No 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending Director: / Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2, To the F complet only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0062223 October 7, 2010

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State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

cress of person who completed cause of death (Item 23a) (Type, Print)

Preaveen Bolarum, MD 196 Thomas Johnson Drive, Suite 135, Frederick, Maryland 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32447 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October Gilbert Moyer Puckett 2010 P^M Medical 8:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 6. Sex 1 X M 2 ☐ F 9. Birthplace (State or Foreign Country) Salem Virginia **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Days May 8, 1921 230-01-2688 Hours **Director** 89 Yrs Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Mary's 1 Yes 2 No Maryland Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40181 Stanley Lane 20659 USA items 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3x Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry United States (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Technician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lelia King Cleveland Thomas Puckett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lisa Ann Miller</u>/ Daughter 40181 Stanley Lane Mechanicsville, Maryland 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State October 12, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 2010 Alexandria, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. whalt P.O. Box 270 Leonardtown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition notes Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical $\mathcal{L}_{\mathcal{U}} c \mathcal{K} e + \mathcal{T}, \quad G / b e$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of preg*nancy*1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year ed by the detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home After this 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 🗌 No after death the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day Year)

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2. Regis rar's Signature

2010

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			For State Registrar		State of Ma	aryland	•		of Health <i>of Deat</i>			eg. No.	UIU	32448
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	death ms 2:	Funeral Directo	11. Marital Status	III AVC	12. Was Decedent Armed Forces?		i. 13. V	Vas Deceden		Origin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White	
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	Sta Regist		31. Date filed (Month)	CT 0 5 2	010 32. Fi gistr	ar s orgnat	A. A	lass	,					

10-07368 Allen H. Palmer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	sicia	ın/	Decedent's Name (First, Middl								2. Date of Deat	h	r	3. Time of Death
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ury o	1	21. dignatural funeral Service			0								HOME, P.A.
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Division of Vital Records, P.O. Box 68 To the Bospital or Attending Physician: The law requires that the death certif within 24 hours after death.	Lo the Functal Director: Attert completely filled in by the funeral	Medical			asis of exam	ination and/	or investigati	on, in my opinio	on, death oc	curred at t	the time, date a	and place, and d	ue to the	cause(s)
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3+ VA "	11.		Mary G. Ripple MD.	Deputy Ch	B2. Registrar			Penn Stree	et, baitim	ore, ML	7 2 1 2 0 1			
		ate rar	31. Date filed (Month, Day Year) SEP 2	8 2010	2. Registral		B. 40	exter						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Robinson October 4, Μ. 2010 9:45 a.mM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours Min. North Carolina 10/10/1934 Director Yrs 241-42-4143 Usual Residence of Decedent ortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland St. Mary's Park Hal. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 47898 Park Hall Road 20667 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Heavy Equipment Operator Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Α. Robinson Mamie McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thlema Robinson/Spouse P.O. Box 2, Park Hall, MD 20667 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grd, 10/09/2010 Leonardtown, MD 21. Signature line il Syrice licens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final CENGESTIVE Onset and Death Enysician/ MEART disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CORUNARY 76m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENITE MALVILE Completed 1 ☐ Yes 2 ☐ Now 3 ☐ Probably 4 ☐ Unknown CO (111) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Director: After this certificate Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical filled in by the funeral director. Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 [Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

29b. Signature and title of ceptific

31. Date filed (Month.

AJBINDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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strar's Signature

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ASSOCIATES

29d. Date signed (Month, Day, Year)

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MOLLYWOOD)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-transit and attending physician as the for use ed by the a signed by t page 2 should has certificate Hospital or Attending Physician: director, After this funeral ithin 24 hours after death.

• the Funeral Director: After ompletely filled in by the fun within 2.

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State Registrar

Medical

31. Date filed (Month, Day, Year)

person who completed cause of death

29a. Certifier

(Check only one)

30. Name and address

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29b. Signature and the of certifier



(Item 23a)

(Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MDC

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 29 Michelle Denise Richeson 5:33AM 2810 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Med. Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕱 F Days Hours Min. **Director** 48 0972871962 228-11-2473 MD Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Anne Arundel Severna Park 1 Yes 2 No 23a or 2 10e Street and Number 10f. Zip Code injury or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 514 Kegworth Court 21146 United States items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò þ 1 Never Married 2 K Married Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Hygiene. 1 ☐ Yes 2 K No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Worker Day Care is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Richard Earl Byrne Shirley Mae Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Glen W. Richeson - husband 514 Kegworth Court Severna Park, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Page 1 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 09/29/2010 4 Donation 5 Other (Specify) Ardent Crematory Hanover, MD of Funeral Service L any ir 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Interval Between Onset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ inhosis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

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Yes 2 No 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital Certificate: To I 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director, After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniun Accident Investigation M 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 29, 2010

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month SE

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ICKS

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Registrar's Signature

neces.

Arnold Rosenfeld State of Maryland / Department of Health and Mental Hygiene 2010 32453 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day Y September 20, 2010 Medical Examiner 1145 hrs Arnold R. Rosenfeld 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1704 Highland Drive Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Romania Country) Director Months 220-70-3389 "unknown" 1 XM 52 2 F Usual Residence of Decedent iny 10a State 10c. City, Town or Location 10b. Count 10d. Inside City Limits is 23a or 28a-f show e notified at once. 28a-f shov 1 Yes 2 No 'none" "none" "none" death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? no residence" "none" "Homeless Person, "stateless" Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married "natural", or Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner II 3 Widowed 4 Divorced If Yes. Give Year Yes 2 X No specify: Specify: White ₽ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** "none" 3 "never employed" 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Alexander Rosenfeld Irene "unknown" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 Hanover Street, Silver Spring, MD 20910 Meir Mayer, cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Chesed Shel Emes 09/22/2010 Capitol Heights, MD 4 Donation 5 Other Specify 21 Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, MD 20852 MO1255 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) rause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical physician the burial -UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records. has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? certificate h Yes 2 ✔ No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this ER/Outpatient 3 DOA 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural hours after death. Director: 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E September 21, 2010 Joule Mahanetro 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

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more Pages 1	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	State C	emetery, cren	sition (Name of natory or other plac		Date		20c. Loca	ation - City or T	own, State	
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			30. Name and address of person w Weihan Wang l	tho completed caus 5225 Shad	se of death (Item dy Grove	23a) (Type, F Rd • S	Suite 130	Roc	kville	e, MD	20850	0		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George Francis Riseling 2010 September 9:25 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Silver Spring 4c. County of Death
Montgomery Holy Cross Hospital . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 578-12-5192 1 🙀 M 2 🗆 F 90 Months Days Hours oct. 14, 1919 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director 10c, City, Town or Location 10d. Inside City Limits MD P.G. Suitland 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2217 Lakewood Street 20746 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No WWII Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", Completed Specify: White 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) At torney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ John J. W. Riseling Teresa M. Gallen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6419 2nd Place, NW, Washington, DC 20012 S Page 1 and 2 sh ment of Health a tant; If item 27 is George Francis Riseling, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. 2010 permit. Page 1 a Department of H Important; If ite 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 XBurial 2 Cremation 3 Removal from State injury or Silver Spring, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ²²Francis Address Colimans Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 any Part 1. Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Acute Renal Failure Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). ysician and solutions and a burial-transit law requires that the death certificate be executed E. Coli Sepsis that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Urinary Tract Infection Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? fο Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached g 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 😾 Unknown Anemia, Hypokalemia, Severe Thrombocytopenia has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 performed? autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director, After this certificate h Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXXI 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State

Registrar

only one 29b. Signature and title of certific

31. Date filed (Mohth, Day, Yea.

29

2010

MID

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Smitha Bhikkaji, Md 1500 Forest Glen Road, Silver Spring, MD 20910

2. Registrar's Signature

29c. License numbe

D64100

29d. Date signed (Month, Day, Year)

September 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day William Sawik October 4, 2010 9:20 a.\m 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center
Social Security Number 6. Sex 7. A St. Mary's Leonardtown

If Under 1 Year

10f. Zip Code

16a. Decedent's Usual Occupation

Fabricator

Days

20659

1 ☐ Yes 2X No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Tatina

Months

Mechanicsville

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year) 03/11/1914

18. Mother's Name (First, Middle, Maiden Surname)

Prock

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2X No

Massachusetts

10g. Citizen of What Country?

16b. Kind of Business Industry

USA

14. Race - American Indian, Black, White, etc.

<u>General Electric</u>

White

Age (In yrs. last birthday)

Yrs

10c. City, Town or Location

96

1 🛣 M 2 🗆 F

Mary's

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.

College (1-4 or 5+)

Examiner Funeral

Physician/

Medical

Director

Funeral

þ

Completed

Be

ပ

For State Registrar

10a. State

Maryland

11. Marital Status

10e. Street and Number

027-12-1902 Usual Residence of Decedent

10b. County

25958 Timothy Court

1 Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

12

Elias

St.

15. Decedent's Education (Specify only highest grade completed)

Sawik

Director uld be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at

yland 21215-0036

<u>a</u>	2 shorth and 27 is retraun		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street and Nun	nber or Rural	Route Number, 0	City or Town, State, Z	ip Code)
Baltimore, Ma	and 2 Health em 27 ther tr		Joan Marchand/S	tep-Daughter	25	958 Timothy Co	ourt. I	Mechanic	sville. M	20659
e e	of He		20a. Method of Disposition		20b. Place of Di	sposition (Name of			20c. Location - City or	
Ĕ	ent ent nrt: If		1 Burial 2 K Cremation 3 C 4 Donation 5 Other (Spec			rematory or other place) ield-Echols	10/07	7/2010	Charlette	II.a.1.1 MT
垂	artmartmorta		21. Signature of Funeral Service Licer	**	DITHSI		-	m. 1. 4	Charlotte	
Ba	permit. Page 1 and 2 sho Department of Health and Important: If item 27 is r any injury or other traun		Shawn Ayleswort	LIN ,		22. Name and Address of Fact 22955 Hollywoo	d Poor	sfield :	Funeral Ho	ome, P.A. 20650
			23a. Part 1. Enter the disease, or con							
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	0 404111 00 1100	sinter the mode of dying, such t	as cardiac or	respiratory arres	ι,	Approximate Interval Between
	Physician/ Medical		disease or condition resulting in death)	a Concept	ive Hen	et toolure				Onset and Death
'n	Examiner		resulting in dealing	Due to (s a co	onsequence of):					
		_	Sequentially list conditions,	n Muosos	Wal look	oseffon_				
	_ +	ine	If any, leading to immediate cause. Enter Underlying	Dut to (or as a co	onsequence of):\)				_
	uted	Examiner	Cause (Disease or linjury that initiated events	· Losuma	ത്മിര					1
	exec an ar rial-t		resulting in death) Last	Due to (or as a co	onsequence of):					
0	e be ysicië e bur	ica		d HTN					ĺ	
Box 68760	ficat g ph as th	Jed							-1	
3	cert andin use	ا ڇَ	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy				23d. Date of de	liven
ô	eath a atte	iğ.	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tin	Tetal death the of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
. E	the d	lys	9 🗌 Unknown	g 🗌 Unknown						
P.O.	that hed b	<u>ح</u> ا	Part II. Other significant conditions of	ontributing to death but r	ot resulting in th	e underlying cause given in Pa	ırt I.	23e. Did toba	cco use contribute to	the cause of death?
Ś	sign Id be	ᇫ						1 ☐ Yes	: 2 No 3 □ P	robably 4 🗆 Unknown
ord	requ beer shou	ete						24a. Was an		topsy findings available
ec	e law e has ge 2	Completed by Physician/Medical						autopsy performe	prior to	completion of cause of
<u> </u>	ysician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit		25. Was case referred to medical					1 Yes 2		2 🗆 No
lta	sicia certi recto	മ	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:		26. Place of De	7			
1	Phy:	<u>و</u>	27. Manuar of Death	1 ☐ Inpatient 28a. Date of injury	2 ER/Outpat	tient 3 LI DOA 4 L			ce 6 🗆 Other (Spec	ify)
n	ding Phy th. After this funeral o	ă	1 Natural 5 Pending	(Month, Day, Ye	ear) injury	work?		Bd. Describe how	injury occurred	
9.0	deat deat tor: / the	≝	2 Accident Investigation 3 Suicide 6 Could not be		A4 h a may farmer	M 1 1 Yes 2	_			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	зтеет, тастогу, опісе	21	8f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	spital ours eral filled	हुं ।	29a. Certifier 1 Certifying Phy	picians To the best of my	knowledge deet	h account of the Post Co.	1			
	Hos 24 h Fun eted	Medical	(Check 2 in Medical Exam	iner: On the basis of exam	ination and/or inv	h occured at the time, date and estigation, in my opinion, death	accurred at the	he time date and	place and due to the	outpa(a) and manner stated
	othe othe		29b. Signature and title of certifier	se Practioner: 10 the best	of my knowledge	e, death occurred at the time, da	ate and place,	and due to the ca	ause(s) and manner as	stated.
	F S F O		1 0 0			NOO70	OMA	290	d. Date signed (Month	, Day, Year)
		-	married to	<u> </u>		10070	900		10/05/10)
2			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	0 0 0 1.10	200	0111-1	
3/0		- 4	11. Date filed (Month, Day, Year)	Colony Da	15 31	UPR JA AM	<u> 2/100/0</u>	INIO	21401	
	State Registra		OCT 11 5 0	32. Registrar's S	oignature	60.4.1	•			
DLIA	MH 17 Rev 7/200		ULI U 3 Z	UIU Jenna	p. A.	PAUL				
DHI	mii 17 nev 7/200	13			•					
					ORIG	INAL				

			State of Maryland / Department of Health a	and Mental I			001 57
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No	2010	3245/
Н	Physici		Inne Fligsboth CNYDED	Month Octobe	Da	y Year 2010	3. Time of Death 5:16 a M
· halipti	/Medic Examin					. County of Dea	
			Homewood at Williamsport Williamspo	ort		Washin	gton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24 Hrs. 8. Date of (Month,	Day, Year)	9. Bir <i>C</i> c	thplace (State or Foreign
6	Director		Usual Residence of Decedent	Aug.	11 19	20 Ma	ryland
	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f s	Director	Maryland Washington Williamsport				1 □Yes 2 No
	vith th	Dire	10e. Street and Number 10f. Zip Code		10g. Cit	tizen of What Co	ountry?
	eath v	Funeral I	16505 Virginia Avenue B-220 21795			USA	
ယ	ifter d ir item	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 No		No-	14. Race - Ame Black, White	
033	ral", o	Ş	3 X Widowed 4 □ Divorced If Yes, Give 1 1 □ Yes 2 K No Specify:			Specify:	White
5-0	72 h "natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	t of working	16b. K	ind of Business/	
121	within ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) 12 O Sales Clerk	. c. meming			
0	be filed within 72 hours after death with the Maryland Hylyiene. ad other than "natural", or items 23a or 28a-f show event, I'm Madical Evana har mast be multiped at			er's Name (First, Mide		partmen	t Store
<u>la</u>	ild be fental rked c	To Be		ie Borne	arej maraen	Carriamo	
Maryland 21215-0036	shou and N is mai		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number		mber, City o	or Town, State, 2	Zip Code)
₹.	and 2 lealth m 27 ner tra		Carolyn O'Hara - Daughter 5100 Highbridge St	reet 4-E,	Faye	tteville	e, N.Y. 1306
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evan har mat by notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or	
Ħ.	it. Pa rtmer rtant: njury		4 Donation 5 Other (Specify) Rose Hill Cemetery 1	0/6/10	Hage	rstown,	Maryland
Ba	Depa Impo any i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as of chart as the order to be a few to b			n, Md.	21740 Approximate
	hysician	1	Immediate Cause (Final	(SAP)	y arroot,		Interval Between Orise and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	CHSC			(CALI)
	Examiner	_	Sequentially list conditions b.				
	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chase (Disease or injury that is (Disease or i				
	be executed ician and burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):	7.			
8760	ricate be executed physician and street the burial-transit	dical	E d				
9	certificate nding physise as the t	/edi	V				
go.	attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deli	ivery
o j	the atten	/sici	in the past 12 months? I Yes 2 Mo 4 Pregnant at time of death 5 Other (specify)		-	Month	Day Year
ב	ed by detac	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Di	d tobacco u	see contribute to	the cause of death?
Hecords,	ulres n sign ld be	Ω.	a Harana Caral Labora Dan Harris Dice	moi		No 3□ Pr	
ဂ္ဂ	noys:	lete	NASSER MONITURE 7	24a. W			topsy findings available
Ĕ	ite ha	Completed	u l l l l l l l l l l l l l l l l l l l	au pe	topsy rformed?	prior to death?	ompletion of cause of
VITA	artifica ctor, p	Be C	25. Was case referred to medical	1 ☐ Yes of Death (Check onl	2 LVNo	1 ☐ Yes	2 □No
> i	his ce	9	Hoepital:	rsing Home 5 Re		6 ☐ Other (Spec	cify)
ט ב	After t	<u>.</u>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day, Year) 28b. Time of 28c. Injury at Work?	28d. Describ			,
DIVISION	death ctor: / the I	icat	2 Accident Investigation M 1 Yes 2 N 3 Suicide 6 Could not be 280 Place of Injury. At home form street feature of the				
בּ בּ	after Direction by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or 7	(Street and own, State)	d Number or Ru)	ral Route Number,
4	hours neral ly fille			d place, and due to t	ne cause(s)	and manner as	stated.
i,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical	(Check only one) On the basis of examination and/or investigation, in my opinion, death and manner stated.	h occurred at the tim	e, date and	place, and due	to the cause(s)
Ę	Zon Con	2	29b. Signature and triplet pertifier 29c. License number		29d. Date	e signed (Month	, Day, Year)
		-	MULL MEXCEN MACGAN 1)1 De	5)	1	0/4/0	010
3+	1-4		30. Name and address of terifon w/o completed cause of treath (Item 23a) (Type, Print)	IN Har	Fn (4)	enal L	1/9/7/
	State	9	31. Date filed (Month, Day, Year) 32. Registrar's Signature	10/11/	C16 7/6	, n	10001 192
	Registra						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 27, Physician/ 2010 Schaeffer 10:25A M Nancy S. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shanti Home Prince George's Laurel Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours (Month, Day, Year) Peb 2, 1925 North Carolina 1 M 2 X F Months Yrs **Director** 242-22-4934 85 Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural". or items 23a or 29a-f ehw 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f sho edir al Examiner must be notified at Director Maryland 1 Yes 2 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15815 Wayne Avenue 20707 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-11 Marital Status 14 Race - American Indian Armed Forces If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 X No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Telecommunications Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ (unk) (unk) traumatic Summers Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles K. Schaeffer/husband 15815 Wayne Avenue Laurel, Maryland 20707 Department of Health Important: If item 27 any injury or other to Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 10/1/2010| Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home of Address CF and the Connection Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 uanita M00957 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Many years Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2X No 1 Tes Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Assisted-은 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Living Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Division of Vital Records, after death 24 hours a Funeral I

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, Maryland 20707 Rajkumar G. Bhoirai 704 Gorman Avenue #T-1 M.D. 32. Registrar's Signature State Registrar

perp M

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D23181

29d. Date signed (Month, Day, Year)

September 29, 2010

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Physician/ Medical Examiner **Funeral Director** must be notified at 28a-f ō 23a items 27 is marked other than "natural", or iter traumatic event, the Medical Examiner nould be filed within 72 and Mental Hygiene. 1 and 2 should be file of Health and Mental Fitem 27 is marked o Page 1 Department of Important: If it 5 injury any enysician/ Medical Examiner Examiner sician and burial-transit attending physician for use as the buria Physician/Medical that the death certificate be the detached à δ

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 69 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 05/28/55 1 M 2 D F Months Days Hours Min. Yrs 214-70-2323 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 🔀 No MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Locust Grove Drive 20707 U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ♣ Divorced If Yes, Give Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Construction Construction Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James L. Powell Estelle C. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron L. Powell/brother 8780 Rose Lane, Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Buria 2 ☐ Cremation 3 ☐ Removal from State etery, crematory or other place Maryland Nat'l Mem Pk 09/29/10 Laurel, MD 4 ☐ Doylation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Sign of Funeral Service Lie 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or conshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Embolist ulmonory Due to (or as a consumence of) emic SIrnk Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be det 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed? Yes 2 No death? certificate 2 No Division of Vital Hospital or Attending Physician: within 24 hours after death.

• the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No ည 1- Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the } Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated 29b. Signature and title of certifier AO 4176435B 100552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore ZZ S Green 5¥. State Registrar

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ September 28, 2010 Year 8:50 a Mary Shepherdson Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 15301 Pine Orchard Drive, #1E Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗗 F Months Days Hours Alig. 1924 399-18-7941 86 IL **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 🗆 Yes 2 🏲 No Mon topomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 15301 Pine Orchard Drive, #1E 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, ould be filed within 72 nd Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clifford Philip Strause Margaret Anderson 1 and 2 should bot Health and Meritem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4526 Amherst Lane, Bethesda, MD 20814 Daniel Paul Shepherdson/Son injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place
Metropolitan Crematory crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myasthenia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a Id be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2: autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 10 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide after death Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signato 29d. Date signed (Month, Day, Year, D12121 September 28, 2010 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of George Sengstack MD 3929 Ferrara Drive, Silver Spring, MD 20906

State Registrar

		State of Maryland / Dep		1ental Hygier	ne	
			rtificate of Death	Reg.	No. 2010	3246
Physici	ian/	1. Decedent's Name (First, Middle, Last) Ruth K. Schneider		2. Date of Death Month	Day Year	3. Time of Death
Med	ical		T	٩	21 2010	10',10A M
Exami	ner	4a. Facility Name (if not institution, give street and number) Hebrew Home of Greater Washington	4b. City, Town, or Location of Death		4c. County of Death	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgon	nery lace (State or Foreign
Directo		063-03-7917 1□M 2X□F 92 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Count	York
1 × 1		Usual Residence of Decedent		Dec. 10.		1018
Oktone in the part of the part	ctor	10a. State 10b. County 10c. City, Town or Lo	ocation		11	0d. Inside City Limits
e Mar r 28a notifi)ire	MD Montgomery Rockvi				1 🔀 Yes 2 🗌 No
ith th	Funeral Director	1801 E. Jefferson Street #223	10f. Zip Code	10g.	Citizen of What Coun	try?
ath w	nue,	11. Marital Status 12. Was Decedent Ever in U.S. 13.	20852 Was Decedent of Hispanic Origin? (Spe	city Yes or No-	USA 14. Race - America	an Indian
6 ter de mine	by	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
within 72 hours after death with the Maryland giene. The matural, or items 23a or 28a-f show the Medical Examiner must be notified at.	ted	3 ★Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🙀 No Specify:		Specify: Whi	te
21215-0036 within 72 hours after giene. her than "natural", o	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ng 16b	o. Kind of Business Ind	lustry
thin 7	5	Elementary/Seconday (0-12) College (1-4 or 5+)	OO NOT use retired)			
d Hygier ent, t	Be (12 Boo	kkeeper 18 Mother's Name	e (First, Middle, Maide	Key Food	
lan be fil ental rked ic ev	ြု	Isadore Kaplan	Rose Pete		on damanoy	
ary hould and N s ma		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura		or Town, State, Zip C	ode)
nd 2 s alith a n 27 i		Debra Grossman/Daughter 8100	Whirlwind Court,	Gaithersb	urg, Maryl	and 20882
of He		20a. Method of Disposition 20b. Place of Dispo	osition (Name of gratory or other place)	Date 20c	. Location - City or To	wn, State
Lim Pag Iment tant: jury o		4 Donation 5 Other (Specify) Wellwoo	d Cemetery 9/29/		rmingdale,	New York
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.			2. Name and Address of Fadiward			
			091 Rockville Pike		le, Maryla	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac c	r respiratory arrest,	Į.	Approximate Interval Between Onset and Death
Pnysician Medica		Immediate Cause (Final disease or condition resulting in death) a. Ur D 5(2 P 5 i 5) Due to (or as a consequence of):				Onoct and Beath
Examine	1	Due to (or as a consequence or).				
	je je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
uted od ransit	all	cause. Enter Underlying Cause. (Disease or illipid) that initiated events c				
e exectian ar	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
Box 68760 death certificate be executed re attending physician and ed for use as the burial-transit		d				
687 certifica nding p	NA.	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box 687 death certifice the attending p	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ry Day Year
he de y the iched	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
DIVISION OF VITAI RECORDS, P.O. B tal or Attending Physician : The law requires that the de rs after death. al Director . After this certificate has been signed by the a ed in by the funeral director, page 2 should be detached	S P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
dS, quires en sig	ed	CVA		1 Tes	2 ØNo 3 ☐ Prob	ably 4 🗆 Unknown
aw rec	ple	Atrial Fibrillation		24a. Was an autopsy	24b. Were autop	sy findings available npletion of cause of
/Ital HeCo sician: The law r certificate has b lirector, page 2 s	Completed by			performed	? death?	_
tal cian: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)		
Physical chiral	은	1 Yes 2 No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	,	-	6 ☐ Other (Specify)	
ding th. After	cate	1- Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	f 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inj	ijury occurred	
Atter Arter or dea ector by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Street :	and Number or Rural I	Route Number,
DIV talor rs afte al Dir		building, etc. (Specify)		City or Town, Sta	ate)	
DIVISION Of VITAI RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the Completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inves	occured at the time, date and place, and	d due to the cause(s)	and manner as stated	d.
thin 2 the F the F	₩	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the caus	se(s) and manner as sta	ted.
PRPS		29b. Signature and title of certifier Aug Sov Timum CKNP.	29c. License number		Date signed (Month, D	
		30. Name and address of nerson who completed cause of death (Item 23a) (Type I	R172412			, 0
		Alyson Timin (RMP (alz) Mon.	trose Rd. ROCKYII	ic, mo 2	0852.	1
Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature	est.			
Registr	ar	31. Date filed (Month; Day, Year) SEP 29 2010 Line B. Harris Signature				

			For State Registrar		Maryland		artment rtificate			and M	lental Hy	/giene2 Reg. No.	010	321	+62		
Physicia		ian	1. Decedent's Name (First, Middle, Last) WILLIAM LUCIUS SCOTT 2. Date of Death Month Day Year 09 22 2010												Death		
	/Medi Examii		4a. Facility Name (If not institution 53 DAVIS LANE			Town, or	Location o	of Death	09		4c. County of Death TALBOT		26 P M				
	Funeral Director		5. Social Security Number 089-05-5600 Usual Residence of Decedent	6. Sex 1 X M 2□ F	. Age (In yrs. la	a <i>st birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 08/13/	rth ay, <i>Year)</i> 1911	9. Birthp Coul	place (State of	or Foreign A		
	ryland how	_	10a. State 10b. County		10c. City, Town or Location							10d. Inside City Limit					
	with the Maryland a or 28a-f show be retilled at	Director	MD TAL	вот		EASTON							1 X Yes 2 □ No				
	with the		10e. Street and Number 53 DAVIS LANE		10f. Zip	Code 1601			-	of What Cour D STATE							
21215-0036	hin 72 hours after death with the Maryland e. "natural", or items 23a or 28a-f show Medicel Exeminar must be multiled at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 Named Forces? 1 Yes 2 Named Forces. 1 Yes 2 Named Forces. 1 Yes 2 Named Forces. 1 Yes 2 Named Forces. 1 Yes 2 Named Forces. 1 Yes 2 Named Forces. 1 Yes 2 Named Forces. 1 Yes 3 Named Forces. 1 Yes 3 Named Forces. 1 Yes 2 Named Forces. 1 Yes 3 Named Forces. 1 Yes 4 Named Forces. 1 Yes 4 Named Forces. 1 Yes 4 Named Forces. 1 Yes 4 Named Forces. 1 Yes 4 Named Forces. 1 Yes 4 Named Forces. 1 Yes 5 Named Forces. 1 Yes 5 Named Forces. 1 Yes 6 Named Forces.			in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working						0- 14. Spi	14. Race - American Indian, Black, White, etc. Specify: WHITE 6b. Kind of Business/Industry ETAL AND FIBRE				
d 21	filed w Hygiel ther ti	e Co	17. Father's Name (First, Middle, L		SALI	ESMAN	-	18 Mothe	r'e Namo	/First Middle	CONTAINERS ddle, Maiden Surname)						
lan	ald be i dental rked o	To Be	WILLIAM L. SCOT	*					SARA			e, ividiueri Sur	nane)				
Maryland	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Mental Hygiene.		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	g Address	(Street a	nd Numbe	er or Rura	l Route Numb	oer, City or To	wn, State, Zip	Code)			
	1 and Health em 27 ther tr		CHARLES BERRY / 20a. Method of Disposition	STEP-SON	20h Ble							LLE, M					
nor	ages ent of nt; If it y or o	'	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ace of Dispo metery, cren LNG HI					ate /2010		on - City or To	wn, State			
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L			\ FI	. Name and	Addres	s of Facility	BEIN	-	NAM FUI	NERAL E 21601		P.A.		
8760,	Physician and /Medical Examiner transit the private transit the private transit the private transit tr	dical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	cute		ocar A	rdi	al	In 1	Jar	ction ese	2	Approximate Interval Beth Onset and I	ary		
O. Box 6	The law requires that the death certifica tite has been signed by the attending phage 2 should be detached for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	me of pregnan th 2 □ Fetal o nt at time of de n	etal death 3 Ectopic pregnancy						23d. Date of delivery Month Day Year						
rds, P.	w requires that been signed be should be deta		Part II. Other significant condition Hyperlo	use giver	n in Part I.	n Part I. 23e. Did tobacco use contribute to the cause o											
of Vital Records,	s ician: The law re certificate has be rector, page 2 sh	Completed by	autopsy prior performed2 deat 1 □ Yes 2 No 1 □									tb. Were auto prior to cor death? 1 ☐ Yes	npletion of ca	available ause of			
Vit	Physician: r this certifica ral director, p	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	-1	7/0		Other			(Check only o						
	Attending Phys ir death. ector: Affer this by the funeral dii	ation: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of 28c. Injury at 28d. Describe how injury occurred												
Division	ital or Atters after der al Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one)	Physician: To the be xaminer: On the basi and manner	s of examination	ledge, death on and/or inv	estigation, i	in my opi	inion, deat	d place, a	and due to the	cause(s) and date and place	d manner as s ce, and due to	tated. the cause(s))		
	vitl Cor		29b. Signature and title of certifier	aringh	MD	FAC	CA	License	number	41	723	29d. Date sig	$\frac{2}{3}$	Day, Year) - Ο Ι δ) .		
	6 Star		30. Name and address of person w M. C. R. a. a. 31. Date filed (Month, Day, Year)	singh	of death (Item 2 5 3 istrar's Signatur	3 7		wi	19	Ave	nue,	Eas	iton, M	D ZI	101		
	Registra	.~	SEP 242	1010 Example 1	un B	ba	العثل										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lars Svante Svenonius Month September 10:31 Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day 1 X M 2 | F Days 200-30-0469 Months Hours Director 83 Skelleftea, Sweden June Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5002 42nd Avenue 20781 Sweden 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 Yes 2 No Specify: 3 Divorced Specify: White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Il Hygiene. (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education 5+ and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Svenonius Frida Ljunglof permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane B. Svenonius / Wife 736 Silver Spring Ave., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/1/2010 Alexandria, Virginia Signature of Fuperal Service Licenses any in 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Cardiovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hipocalcemia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 X No 욛 1 ☐ Inpatient 2 🛛 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 Yes 2 No After 28d. Describe how injury occurred X Natural 5 Pending nours after death.

neral Director: A
filled in by the fu ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

OCT 0 4 2010

Babette Pennay, 15245 Shady Grove Road, Rockville, MD 20850

rar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

R096053

9/29/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death SUMMERS Physician/ Month OCTO BO Year arrie. 3.50 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Pleasant View Nursing Home Mount Airy If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 M 2 X F Days Hours Min (Month, Day, Year) 8/16/1925 Director 196-14-0268 85 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Carrol1 MD Mount Airy 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4101 Old National Pike 21771 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. d other than Elementary/Seconday (0-12) College (1-4 or 5+) the 8 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked otl jury or other traumatic even Sadie Barbara Hellman George Franklin Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. Summers, Jr. 1318 Stevens Avenue, Arbutus, MD 21227 / Son Department of Healtl Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Metropolitan Crematory 10/3/10 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 4739 Baltimore Avenue 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ -ARDIO PULMONARY ARRES disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CORONART ARTERY DISTASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine HYBBRTENSION The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Smuli Dependent Diabeter 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed GRADE LROTHELIAL CARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? of minary 24a. Was an has autopsy BLODER performed? Yes 2 N this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🗗 No Hospital Other: Certificate: To 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at : After 1 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [] 3 [] (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D. 30469 October 2nd. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NBVPULTNK 8850, Columbia, MD
21

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 4 2010

backs

32. Registrar's Signature

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 32465 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Clifford Hendricks October 1 2010 ear Sharp 9:40A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ▼M 2 □ F Dec. 5, 1912 Days Months Hours Min. 270-12-1590 97 Director Offinty) Usual Residence of Decedent 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Hyattsville 1 X Yes 2 □ No 10e. Street and Number 9 10f. Zip Code rral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 2200 Amherst Road 20783 United States Page 1 and 2 should be filed within 72 hours after death ment of health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items ant If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Year or Dates. WII 3 ₩ Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford M. Sharp Eunice Alma Hendricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dollye Karen Jalloh -daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 2200 Amherst Road Hyattsville, Maryland 20783 20a. Method of Disposition

1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 10/7/2010 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Signature of Funeral Service Licensee Bonald Wessbirgwardt Funeral Home, PA 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Duodenal ulcer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to harmoist cause. Enter Une property in the cause. (Pleasure of the cause of Examiner Day to (or as a nonleggiannia of Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day 2 No signed by the a d be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peritonitis; dementia 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 21 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 💢 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending iniury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

4400 Powder Mill Road Beltsville, Maryland 20705 To the Hospital or Attending Physician: The law requires that the death certificate be executed eral Director: After this filled in by the funeral dir within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D060634 October 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D. 6001 Muncaster Mill Road Rockville, Maryland (Month, Day, Year) CT 15 2010 32. Registrar's Signature State Registrar ORIGINAL

		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of <i>rtificate of</i>		Mental Hy	/giepe	0 (32466	
Physic	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year									3. Time of Death	
/Medi	cal	BULIE KENNETH	or Location of Dea				5:05 pм				
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ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, them that hat matural, or itams 23a or 28a-1 show other traumatic event, the Medical Exponer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No.	Hispanic Origin? (s pan, Mexican, Puel p Specify:	Specify Yes or N to Rican, etc.)	o- 14. Raci Blac Specify	ean Indian, etc. iite		
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d 2.	To Be	7. Father's Name (First, Middle, Last				18. Mother's Na	me (First, Middl	e, Maiden Sumam			
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene, t? Is marked other then "natural", or traumatic event, the Modical Extra		Bulie Kenneth So	Margar	garet Pauline O'Neal							
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C, N 1 and 1 ealth 1 ealth 1 har tr		Earl Schelts 20a. Method of Disposition	(brother)	P.O 20b. Place of Disp	Box 55	Massey	, MD. 2	1650 20c. Location -	City or To	own, State	
Baltimore, Ma permit. Pages 1 and 2 s Department of Health ar important: if item 27 is any injury or other trau once.		1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Speci		cemetery, cre	matory or other pl		13/10	Galena			
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SOX (ath certification)	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су			23d. Date of delivery Month Day Year		
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Physi Physi this c ral dir	. To	1 Yes 2 No	1 ☐ Inpatie		nt 3 DOA	4 Nursing		Residence 6 □Other (Specify) cribe how injury occurred			
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3		30. Name and address of person who Susan K. Ross,		eath (Item 23a) (Type Washingtor		estertow	n. MD. 2	21620			
St: Regist		31. Date filed (Month, Day, Year)		ur's Signature			,				

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

of Vital

Division

1355 Piccard Drive, Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

G. Coleman,
31. Date filed (Month, Day, Year)

SEP 29 2010

D37142

September 27, 2010

9/24/10 0 0510 am Baltimore, Maryland 21215-0036 Tannen Dorothy Division of Vital Records, P.O. Box 68760

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The state of the property of t			Social Security N	Number 1	6. Sex 7. Ag	ge (In yrs. la	last birthday)				(Month, D	irth Da <i>y, Year)</i>	g.	Birthp Count	place (State or Foreign
23a. Part I. Eiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause, Primal resulting in death) Sequentially list conditions, if all products are consequence off; Sequentially list conditions, if all products are consequence off; Due to (or as a consequence off): Due to (or as a co	nd how at	٦					ty Town or Lo	postion			<u> </u>		10 1.5		10d. Inside City Limits
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The property of the property o			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 3 Nours
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FFEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Yes 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 2 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Yes 2 Live Birth 2 Eventhalists Live Birth 2	sit of	niner	if any, leading to im cause. Enter Under	rimediate rlying				, ,,	GC.	J (س) د			+	CW. J
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Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	physicia the bur	edical			d									+_	
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	he death certificity the attending siched for use as	hysician/M	23b. Was decedent pregnant in the past 12 months? 1											*	
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	is that tigned b	ह्य	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cont												./
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	been s	leted	e m character a									Yes 2 No 3 Probably 4 Unknown			
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Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	sician: certific irector,	a a	examiner?		Hospital:			Otho	or:		only one)				
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	ig Fnyster this neral d		27. Manney of Death	1	28a. Date of injury	ry 2	28b. Time of	28c. Injury	4 <u>UN</u> yat			_		ecify)_	
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	ttendin death. :tor: Af / the ful	tifica	2 ☐ Accident 3 ☐ Suicide	Investigat	ation of be	(Month, Day, Year) Injury work? M 1 Yes 2 No									
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	ital or A		4 ☐ Hornicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Loc City								City or Tow	or Town, State)			
Shama R. Mittal, MD 14816 Physician's Ln Suite 152 Rockville State 31. Date filed (Month, Day, Year) 201	the nost thin 24 ho the Fune mpleted f	ΣL	only one) 3	Certifying N	aminer: On the basis of ex	kamination	and/or investi	igation, in my opinion death occurred at the	on, death or e time, date	occurred at t	the time, date a e, and due to the	and place ne cause(s	e, and due to the (s) and manner a	e caus as state	se(s) and manner stated, ted.
State of Date filed (World), Day, Total	2 1 2 1		> She	ama			M			82					
State of Date filed (World), Day, Total		3		^	no completed cause of de	ath (Item 2	23a) (Type, Pr	rint)	icio	10 5	Ln 31	ite	te 150	Ro	chville MI
Registrar CED 2.9 2010 A. A. A. A. A. A. A. A. A. A. A. A. A.		.e	31. Date filed (Month,	, Day, Year)	2. Registrar		re fact		1010	N 3	hilou	J FC			20850

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Í	Physic	ian	1. Decedent's Name (First, Middle, Last)			(1)	Date of Death	Day O Year	3. Time of Death
	/Medi Examir	cal	Aiden Wilson Thore 4a. Facility Name (If not institution, give street and number)	en	4b. City, Town, or	Location of Death	turun nu	Day 22 ZO 0 4c. County of Death	12'31 FM
	LAdiiii	ICI	The Johns Hopkins Hospital		Baltimore	City		None	
	Funeral Director		unknown 1tm 2□F	n yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea ept 20,	2010 9. Birthpl Countr Mai	ace (State or Foreign y) ryland
	yland now		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation			10	Od. Inside City Limits
	e Man Ba-f sh liffied a	ctor	MD Howard	Ellicot	tt City				1 ☐ Yes 2 No
	ath with th 23a or 2 ust be no	Funeral Director	10e. Street and Number 5421 Wooded Way		10f. Zip-Code 2104	4	10g. (Citizen of What Count USA	ry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ک</u>	11. Marital Status 12. Was Decedent Ever Armed Forces? 13. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, Sive Year or Dates:	If	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2X No	spanic Origin? (Specifin, Mexican, Puerto Ricins Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, et Specify: Wh-	tc.
21215-0036	vithin 72 ho ine. than "natul e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A	(Give k	lent's Usual Occupa kind of work done of OO NOT use retired)	furing most of working	16b	. Kind of Business/Ind	lustry
d 2	filed v Hygie other 1		17. Father's Name (First, Middle, Last)		IVA	18. Mother's Name (F	First, Middle, Maid	N/A den Surname)	
/lan	uld be Mental irked c	To Be	Aaron Thoren			Amy Wi	lson		
Maryland	2 sho		19a. Informant's Name/Relationship (Type. Print) M/M Aaron Thoren Parents	l l		and Number or Rural F			
	s 1 and 2 soft Health ar item 27 is other trau			20b. Place of Dispos	Wooded W	Date	cott Cit	Location - City or Tow	
ē	Pages nent of I int: If ite iry or of		1 Burial 2 ☐ Cremation 3 ☐ Removal from State Graph of the Control of the Con	columbia	Mem. Par	e) !		arksville,	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. 4]	Name and Addres	olumbia Pi	H. Witz ke, Elli	ke Funeral cott City.	Home, Inc
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between
* .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due tower as a co	tal hea	rt dis	sease	-		Onset and Death
	Examiner			risequence oi):					
	sit ud	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a co	nsequence of):		-Qr			
	xecute and al-trans	Exar	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a co	insequence of):	·			- III	
68760,	rificate be executed g physician and as the burial-transit	Medical	d						
			IF FEMALE: 23c. If yes, outcome of p	regrancy					
P.O. Box	the death of the attence to the death of the attence to the death of the the death of the death	Physician/	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
	The law requires that the death certif the has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
Records,	ne lay has ge 2	Completed					24a. Was an autopsy performed?	prior to com	sy findings available appletion of cause of
VIta V	w —	Be	25. Was case referred to medical examiner?			26. Place of Death (Cl			
5	Phys this rald	2	1 Yes 2 No Hospital: 1 Inpatient 27. Magner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA Othe	4 - Inursing nome	5 Residence Describe how in	6 Other (Specify)	
ion Ion	Attending I or death. ector: After by the fune	atior	1 Natural 5 □ Pending (Month, Day Yea. 2 □ Accident investigation		Work	? ′es 2 □ No		jary dodanou	
=	F 25 E C	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (Sp.		et, factory, office	28f.	Location (Street City or Town, Star	and Number or Rural te)	Route Number,
	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in t	ledical	29a. Certifier (check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner stated.	knowledge, death omination and/or inve	occurred at the tim estigation, in my op	e, date and place, and inion, death occurred	due to the cause at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
	vith To th	Ž	29b. Signature and title of certifier		29c. License			Date signed (Month, Da	
		-	30. Name and address of person who completed cause of death	(Item 23a) (Type B		5-000	Sec	ptember o	W1 7010
	١		Jessica Clarke-	Pounde	him	600 No	rth Wolfe	St, Baltimore	e, MD, 21287
Ā	Sta Registra		31. Date filed (Month, Day, Year) SEP 2 9 2010 32. Begistrar's S	ignature	aked				

			For State Registrar	State of Ma	arylan		artment of H		nd Mer		iene	0 3	2470
\$	Physici	an	1. Decedent's Name (First, Middle, La	Vasquez	[]	manzo	r			Date of Deat	3 Pa 2010		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi Magnolia Gar	ve street and number)			4b. City, Town, o				4c. County	of Death	eorge's
200	Funeral Director		579-13-0086		6 (In yrs. 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2		Date of Birth (Month, Day, 5/17/	1 ⁹ 53	9. Birthplac Country, E1 Sa	e (State or Foreign lvador
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgo	omery		y, Town or Lo	Spring					10d.	Inside City Limits 1 ☐ Yes 2 🖺 No
	h with the	ai Direc	10e. Street and Number 2319 Blueric	lge Avenue	e #1	09	10f. Zip Code 20	902		11	0g. Citizen of W	hat Country	
980	be filed within 72 hours after death with the Maryland that Hyglene. ad other then "natural", or items 23a or 28a-f show event, it is Marileal Examinational be mailified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Tyes 2 K If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 Yes 2 No El Sa	_ Specify:		/ Yes or No- an, etc.)		- American k, White, etc Whi	
Maryland 21215-0036	e filed within 72 ha at Hygiene. I other then "natu vent, "na Madical	ompietec	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)		+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Homemak	during most (d)	of working		16b. Kind of Bu		itry
/land	should be filed and Mental Hygin marked other matic event, I	To Be C	17. Father's Name (First, Middle, Las Dionicio Vier	a	-			18. Mother Luc	s Name (F. Cia V	irst, Middle, A asque	Maiden Sumame 2 Z	9)	
	lith ar 127 is 1 trau		19a. Informant's Name/Relationship Victor Umanzor	(Type, Phusbar Ferrufii	10/	2319	Blueri		Ave.#	109 S	Silver	Spri	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item eny injuryor other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec	//	C	emetery, crer te of	sition (Name of matory or other pla	1 1 C	-	1010		Spr	ing,Md.
Ball	Depart Depart Import eny in		21. Signature of Juneral Service Lice	relot		9		Lumbia	a Blv	d.Sil	ver Sp	oring	,Md20910
8	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that caused one cause on each lin	the deati		er the mode of dyi	-		,		In	pproximate terval Between nset and Death
	/Medical Examiner	Jer	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	b. Due to (or as a	VIC	uence of):	cepha	lo pon	tty				
68760,	cate be executed physicien and the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseq	uence of):					4.4.4		
89 X	certificat Iding phy Ise as th		IF FEMALE:	23c. If yes, outcome	of pregna	ıncy					23d. Date	e of delivery	
P.O. Box	es that the death certific igned by the attending p be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖰 No 9 ☐ Unknown	1⊡Live birth 4⊡Pregnant at 9⊡ Unknown			Ectopic pregnanc Other (specify)	у			Mon		ay Year
Ś	w requires that been signed t should be det	þ	Part II. Other significant conditions	contributing to death bu	it not res	ulting in the u	nderlying cause gr	ven in Part I.			pacco use contri		cause of death?
Division of Vital Record	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours elder death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Completed								24a. Was an autops perform	ned? d	rior to comp eath?	y findings available letion of cause of
fVit	ysiciar us certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆	ER/Outpatier	nt 3□ DOA Ott	200		heck only on 5 ☐ Reside	e) ence 6 □Othe	or (Specify)	
ion o	Attending PP ir death. ector: After th by the funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	28b. Time of Injury	Wo	ry at rk?]Yes 2 □ N		. Describe ho	w injury occurre	ed	
Divis	rs efter de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		iry - At ho :. (Specif	ome, farm, str	eet, factory, office		281.	Location (Sta City or Town	reet and Numbe n, State)	er or Rural R	loute Number,
	To the Hospital or within 24 hours efte to the Funerel Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examina	wledge, death tion and/or in	h occurred at the ti vestigation, in my o	me, date and opinion, death	d place, and h occurred a	due to the ca at the time, da	ause(s) and mar ate and place, a	nner as state and due to th	ed. e cause(s)
)	To t To t	Σ	29b. Signature and title of cenifier	+ , MD			29c. Licen:	6010	U	(9d. Date signed $9-2$		
	•		30. Name and address of person who	completed cause of de	eath (Item	1 23a) (Type,	Print) TAG	-min	2 1c	907	m P D		
	Sta Registr	te ar	30. Name and address of person who S 1 1 U w was A 31. Date filed (Month, Day, Year) SEP 3 0 201	2. Registra	r's Signa	ture face	W.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	ico or maryiana		tificate of D		ind Mich		Reg. No.	0 0247
Physic Medical Exam			,					2. Date of De	ath	3. Time of Death
Wedical Exam	iner	John Micha 4a. Facility Name (if not institution						Month October		0430 hrs
		Pincy Narrows Marina)		City, Town, Chester	or Location of	f Death	4c. County of De Queen Anne	
Funeral				e (In yrs. la:		f Under 1 Y	ear If Under	24Hrs 8 Date of B	irth(MM/DD/YYYY) 9. I	
Director							ays Hours	Min.	For	eign
		301-34-3115 Usual Residence of Decedent	1 M 2 F	71	Yrs.			Jan 9	9, 1939	Country) Ohio
any		10a. State 10b. County		10c. City, 1	Town or Location					10d. Inside City Limits
* .	<u>.</u>	Maryland Queen	Anne's		Ches	tor				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	çç	10e. Street and Number	711110 5			of. Zip Code	,		10g. Citizen of What Co	
ith the Maryland 23a or 28a-f she notified at once	Director	500 Piney Narr	rows Road SI	in #7		21	619			•
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once		11. Marital Status	12. Was Decedent					n? (Specify Yes or No	United	erican Indian, Black,
death r iten	Funeral	1 Never Married 2 Mar	ried Armed Forces?	X No				Puerto Rican, etc.)	White, etc.	Trader, Black,
after (al", o	by F	3 Widowed 4 Divor	ced If Yes, Give Year	A NO	1 Ye	s 2 X N	lo specify:		Specify:	White
ours natur	pg p	15. Decedent's Education (Specif	y only highest grade com	pleted)	16a. Decedent's L	Isual Occup	pation (Give ki	nd of work done	16b. Kind of Busines	
6 n 72 h an "r cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	during most t	n working ii	fe. DO NOT u	se retired)		
003 withii iene. ter th	Ĕ		2		Pilo	t			Commercia	l Airline
21215-0036 21215-0036 Judi be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, L	^{ast)} (unk)				18.Mother's	Name (First, Middle,	Maiden Surname) (unk)
12 Id be Aenta narke	o Be	19a. Informant's Name/Relationship	(Time Briet)		406 14-00- 44	1				
MD 2 rd 2 shou ulth and M m 27 is n	٦								mber, City or Town, Sta	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death wiment of Health and Mental Hygiene. Rant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be		Cheryl L. Holt/ 20a. Method of Disposition	wite	20b. Pla	500 Pin	(Name of c	rrows I	Road Slip	#7 Chester	
Ore ges l it of li		1 Burial 2 X Cremation		ite cre	ematory or other p	lace)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Departure of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		4 Oonation 5 Other Special Service Li	cify:	Fina	l Journe	y Cre	matory	10/12/10	Woodbine	, Maryland
Ba Deem Depa Injur	d	Juanta RC	10	MOOO	Goin	g Hom	ë Crema	ation Serv	rice P.O. B	ox 784
Physician	7	23a. Part I. Enter the disease, or co	mplications that caused	M009 the death. D	o not enter the m	CIУ Li ode of dying	. HECKI	COTTE, P.A.	est. shock, or heart	Lle, MD 21029
/Medical	- 1	figure. List only one cause or Immediate Cause (Final disease	each line. a. Contact §							Between Onset and Death
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		Sequentially list conditions,	b							
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760, icate be physici the buri		IF FEMALE:	23c. If yes, outcom			<u> </u>	<u>/ 1</u> 1/30	710 11	23d. Date of delive	у
Ox 68 ath certificate attending for use as	/sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at t	ime of death	2 Fetal de		Ectopic p	regnancy	Month	Day Y ear
Box 68 e death certif the attending ed for use as	ysic	1 Yes 2 No 9 Unkno		inc or deat	5 Other (Specify)				
that the death certifended by the attending detached for use as	Phys	Part II. Other significant condition	s contributing to death	but not resu	ulting in the under	lying cause	given in Part I	1. 23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the state death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	a p							1 Yes	2 No 3 Pro	bably 4 Unknown
ords, w requires been should	Completed			_					an 24b. Were a	utopsy findings available
e has	튑							autop perfor	med? death?	completion of cause of
Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical	<u></u>			26 Plan	a of Dooth (Ch	1 Yes :	2 No 1 Y	es 2 No
/ita /siciar /siciar	ă۱	examiner?	Hospital: 1 Inpatien	t 2 EF	R/Outpatient 3	DOA	Other:		Residence 6 🗸 Othe	r Coope
of \oldsymbol{of} \left\{ g Phy} ther ther ther theral or the theral of the ther	읽	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea		Bb. Time of Injury		ury at Work?		now injury occurred	7. Scerie
on cadinate.	힐	1 Natural 5 Pending	10/2/201		:09 pm	1	Yes 2 No		shot self	
/iSi or Att ter de rirect in by 1	[일	2 Accident Investig 3 X Suicide 6 Could n	28e Place of Inju	ry - At home	e, farm, street, fac	tory, office I	building, etc.	28f. Location (S	treet and Number or Ru	ural Route Number, City
Divoital of the sale of the sa	Certification:	4 Homicide		use				or Town St	tate) Pincy Na ster, MD	rrows Marin
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge,	death occurred at	the time, d	ate and place,	, and due to the cause	e(s) and manner as stat	ed.
Fo the vithin Fo the comple	Medical	one) 2 Medical Examin	er:On the basis of exami and manner stated.	ination and/	or investigation, in	n my opinior	n, death occur	red at the time, date a	and place, and due to th	e cause(s)
L > F 0	ŠΓ	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
		anal 2.				O.C.	M.E.		October 3, 2010	
` .	1	30. Name and address of person wh	o completed cause of dea	ath (Item 23	a)					
-			ant Medical Exami		1 Penn Stree	t, Baltimo	ore, MD 21	201		
Sta	te	31. Date filed (Month, Day Year)	2010 32. Registrar's		1. Sark					
Regist	લા	00100	2010 Keneu	a p	· square	Garage Contract Contr				

			1 - For State AMEND#5, PER F	H, 10-5-10, BM	N,MbCb	Cer	tificate of L		iu Meritari	Reg.			
	Physicia	n/	1. Decedent's Name (First, Middle, La Lorraine	st)			Weiss		2. Date of Month		Day Year 201	3. Tim	e of Death
	Medic Examin	al	4a. Facility Name (if not institution, giv	e street and number)			4b. City, Town, o	r Location of D			4c. County of Dea		:00p M
	LAdillii	Gi	3701 Internationa		45		Silver S				Montgome		
	Funeral Director		151 14 6126	Sex 7. Age	e (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days			Birth Day, Yea /192	g. Bii Co Po	thplace (Sta puntry) Land	te or Foreign
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside	e City Limits
	farylar Ba-f s tified	Director	Maryland Montgom	ery	Silv	er Sp	ring					1 🖾	Yes 2 ☐ No
	a or 2 be no	١	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	ountry?	
	th with ms 23 must	Funeral	3701 Internationa			I _{40.3}		0906	0.00			SA	
0500-c	if filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.			Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🗽 No		? (Specify Yes or I uerto Rican, etc.)	40-	14. Race - Ame Black, Whit Specify: W		
1212-	thin 72 hou ane. than "nat u ne Medica	Completed	15. Decedent's I (Specify only highest g		+)	(Give I life. D	lent's Usual Occup kind of work done of O NOT use retired)	during most of	working		. Kind of Business		
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land	ild be fill Mental narked o	2	Sol Baron						Globers				
lary	should and Me is mar raumati		19a. Informant's Name/Relationship (g Address (Street a						
≥ 'ù	and 2 s Health em 27 ther tr	5	Marcia L. Greenbe	rg, daught			Park Pot	tomac A			otomac,		0854
paltimore	permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	ce	metery, crem Leban	on Cemete	ry 09		Ad	elphi, M	aryla	
0	permi Depar Impo any ir once.		21. Signatur Fune Jervic Licen		1255	E.	DWARD SAC 091 Rocky	JEL FUN ville P	ERAL DIF	ECTI kvil	ON, INC. le, Mary	land	20852
u.	Prysician/	8 3	23a. Par/1. Enter the disease, or comsheck, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused	the death.	. Do not ente	r the mode of dyin				9	Approxii Interval	Between nd Death
	Medical Examiner		resulting in death)	a. Due to (or as a			I GALLOL C					J 1110	
		er	Sequentially list conditions,	b. — Due to (or as a	conseque	ence of):					_		
	ansit	amir	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events	6									
5	icate be executed by physician and is the burial-transit	Nedical Examiner	resulting in death) Last	Due to (or as a	conseque	ence of):							
	ificate ng phy as the	Med	IF FEMALE:										
Ď YOU	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnance Other (specify)	у		_	23d. Date of de Month	livery Day	Year
, ,	ires that th signed by d be detac	þ	Part II. Other significant conditions of	contributing to death bu	ut not resul	Iting in the ur	nderlying cause giv	en in Part I.			use contribute to		
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ر ج	an: Th tificate tor, pa	Be Co	25. Was case referred to medical				26. Pla	ace of Death (C	1 🗆 Ye Check only one)	s 2 X	No 1 ☐ Yes	2 □ No	
Ž	nysicii nis cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2□E	R/Outpatien	t 3 □ DOA Othe	er: 4 🗆 Nursin	ng Home 5🏿 R	sidence	6 Other (Spec	ify)	
5	anding Pt sath. rr: After the ne funeral	Certificate:	27. Manner of Death 1			8b. Time of injury	28c. Injury work M 1 □		28d. Describ	e how inj	ury occurred		
	tal or Atturs after de al Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.		ne, farm, stre	et, factory, office			Street a own, Sta	and Number or Ru te)	ral Route Nu	mber,
	the Hospi in 24 hou the Funer	Medical	(Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination a	and/or investi	gation, in my opinio	n, death occurr	red at the time, dat	e and pla	ce, and due to the	cause(s) and	manner stated.
	2 100		29b. Signature and title of certifier	. /	\supset		29c. License D535				tember 2		10
	′		30. Name and address of person who Dr. Daphna Henkin					103	Olney N	rvla	nd 2083	2	
	Stat		31. Date filed (Month, Day, Year)	\$2. Registra				. 100,	OTHEY, P.	<u> y 1</u> a	2003		
	Registra	r	SEP 29 2010	Senera	Ja.	Mark							

State of Maryland / Department of Health and Mental Hygiene Richard Martin Whitby 1- For State #18, FH, TCHD, 10/06/10 Certificate of Death Amended Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 25, 2010 1413 hrs Medical Examiner RICHARD MARTIN WHITBY 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Easton Talbot 9613 Gannon Road If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min Director 212-45-0078 Country MARYLAND 1X M 2 F 15 Yrs MAY 17, 1995 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 X No 28a-f shov rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland spartment of Health and Mental Hygiene, unstrural", or items 23a or 28a-f sho uportant: If item 27s an artised other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Esaminer must be notified at once. TALBOT EASTON Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9613 GANNON ROAD 21601 USA Funeral 12 Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Ves Specify: WHITE 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year 5 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene. 21215-0036 STUDENT 10 0 STUDENT 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALVIN MARTIN WHITBY, JR. TAMMY MARIE COWGET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN M. WHITBY, JR., FATHER 9613 GANNON ROAD, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State LANDING NECK CEMETERY 10/01/2010 TRAPPE, MARYLAND 4 Donation 5 Other Specify. 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 SOUTH HARRISON STREET, EASTON, MD 216 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximation. Approximate Interval Part I. Enter the disease, or complic Physician Between Onset and /Medical a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initi Due to (or as a consequence of): events resulting in death) Last and Physician/Medical the attending physician a led for use as the burial -AMENDED UNPENDED Box 68760, e death certificate be IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 歹 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been il director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject hanged self FOUND: Natural 1 Yes 2 V No 5 Pending Director: d in by the f Sep 25, 2010 1400 hrs Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 9613 Gannon Road, Easton, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 26, 2010 O.C.M.E. 30. Name and address of perg who completed cause of death (Item 23a) GEME **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MC 31. Date filed (Month, Day Year) 32 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 PM 2:45 Sept Dongying Yu Medical 4a. Facility Name (if not institution, give street and number) 🖿 Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Country) **Director** 86Yrs China 212-63-9531 Feb. Usual Residence of Decedent fshow 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11719 Devilwood Dr. 20854 China 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. ğ 1 Never Married 2 Married 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify. 3 X Widowed 4 Divorced Asian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည "Unknown" Mao "Unknown" Yu permit. Page 1 and 2 should be Department of Health and Men-Important: If Item 27 is marke any injury or other traumatic t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11719 Devilwood Dr. Potomac, MD 20854 Huizhen Zhang, Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Ft. Lincoln Crematory 9/28/2010 4 Donation 5 Other (Specify) Brentwood, Maryland Simple Tribute Signature of Funeral Service Licensee 22. Name and Address of Facility M01463 1040 Rockville Pike, Rockville, MD 20853 23a. Part 1. Enter the disea shock, or leart failure Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death ે (iysician/ eura disease or condition Medical resulting In death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter engerlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death.

Funeral Director: After this certificate has been account. Due to (or as a consequence of) resulting in death) Last ed by the attending physician a detached for use as the bunal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 Unknown g 🗌 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No autopsy this certificate Yes 2 No 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes Certificate: To 1 PInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number SEPTEMBER 22 2010 J. Lucehe M.D. 00068080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville. Sircesha Jalli, MD 9901 medical Center Drive 31. Date filed (Month, Day, Year) Registrar

17

September

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Shafi 2237 PM 2010 /Medical Kun 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWES Bultimore RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔯 F Months Director 217-11-4046 43 12, Aug Nigeria 1967 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director MD Baltimore 1 ☐ Yes 2√ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk "natural", or Items 23a or 2229 Southland Road 21207 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify. Specify: black. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, Item" Elementary/Secondary (0-12) College (1-4or 5+) 12 0 self employed housekeeping 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Sikuri Adekunle ျှ Elizabeth Adekunle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shekinatu Fasancy/daughter 2001 Westwood AVenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any Injury or ot Date 20c Location - City or Town State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5ĬOther (Specify) in state S Wad 21. Sign sure of Funeral Sure State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Called Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) I ☐Yes 2 ☐ No the detached 9 ☐Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Tyes 2 TNo 3 TProbably 4 TUnknown Completed Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate performed: 1 □ Yes 1 ☐Yes 2 ☑No 2.K.No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOUS9736 Octobe. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 403PITAL OLD COJRT ROAD 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Virginia Call Arevalo October 6:20 A.M Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Chapel Hill Nursing Home Randallstown Baltimore 1 Year If Under 24 Hrs. Funeral 5. Social Security Number Age (In vrs. last birthday If Under 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 1 - M XX F Months Days Hours Min Director 214-96-5598 89 Yrs. Salvador Aug. 1921 ET Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2XXNo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral 958 Shirley Manor Road 21136 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedon. Armed Forces? 1 ☐ Yes 2XXNo 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after 1XXYes 2 No Specify: E1 Salvadorian Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White "natural", 3XXWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) 11th College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be Rafael Cruz Virginia Colindres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 Page 1 and 2 Thirza C. Cruz (Daughter) 958 Shirley Manor Road, Reisterstown, Maryland item Date 20, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of P 20c. Location - City or Town, State Faiths Crematory & Chape1 1 Burial 2XXCremati Important: If 3 Removal from State A17 injury (4 Donation 5 D Other (Specify) 2010 Manchester, Maryland unaturo I Fune el la Woo Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Next. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician/ Senile Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Arterial Disease 1 Yes 2 No 3 Probably XX Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director. After this certificate has page 2 performed? 2 🗌 No 1 Yes 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 **X**X_{No} Certificate: To Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Examiner: On the basis of examination and/or investigation, in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cur R088852 October 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Kathleen C. Diamond,

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

#203, Baltimore, Maryland 21209

2835 Smith Avenue,

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ Ronald G. Bassett 0950 AM Medical Facility Name (if not institution, give street and number) **Examiner** 4c, County of Death t the ISbury WICOMICO Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Ye)
June 30, **Funeral** 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Months Days Hours 215-38-0133 75 Yrs. **Director** 1935 June New Jersey Usual Residence of Decedent or 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2√☐ No Worcester Ocean Pines 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Rabbit Run Lane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 □ No If Yes, Give Year or Dates.

;53-5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura", or any injury or other traumatic event, the Medical Exami any injury or other traumatic event, the Medical Exami app. once. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white Completed 3 Widowed 4X Divorced ;53-56 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) realtor properties Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antoinette McHernan Floyd Francis Bassett Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25368 Fairway Drive Quantico, MD 21856 Greg Bassett/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronala S. W State Anatomy Board 655 W. Baltimore Street 1timore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Nuse (Final Onset and Death Physician/ MALIGNANT disease or condition resulting in death) CARCINGUA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine day leading to introduct cause. Enter Underlying Due to (or as a consequence ory, b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 performed autopsy Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 2. No Hospital Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) HOS 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

130

733

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PU

Registrar's Signature

WAM

31. Date filed (Month, Day, Year) OCT 18 2010

December Mash March Mash Ma				For State Registrar	State of Mar		artment of He ertificate of E			iene eg. No.2010	32478
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Baltimore MD 21201 Baltim	II II II	it. Pages intment of intant: If it injury or o		4 □ Donation 5 ▼ Other (Specity)	n state			-			
Physician / Medical Examiner Physic	g	perm Depa Impo any l		Ronald S. Wa	de Dire	/		-	655 W.	Baltimore	Street
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Due to (or as a consequence of): Due to (or as a consequence of):		pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
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Acception of the property of t	חם ווכ	ding Phys		27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injury	at			ity)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	DIVISI	after death after death Director: d in by the	ertifica	a Could not be	28e. Place of injury building, etc. (- At home, farm, st (Specity)			28f. Location (Si City or Town	reet and Number or Ru n, State)	ral Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 - 4 - 10. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAY 2 All 35 HAT 368 www Street Hage Account 70 2 1740. State 31. Date filed (Month, Day, Year) 2. Registrar's Signature		ne Hospita 24 hours ne Funeral detely fillex	dical	one)	and manner state	(amination and/or ir d.	ivestigation, in my opi	inion, death occur	red at the time, d	ate and place, and due	stated. to the cause(s)
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Registrar			e	31. Date filed (Month, Day, Year) 0C1 1 8 2010	2. Registrar's	Signature	Kel 1	ags ra	m 11D		

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death													
	Physici	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death											
	Medi	cal			CLAYTON	FO	REST	BOGARI			Month Octob	er 7	y 2010	10:46 PM
	Exami	ner		_	estreet and number) ial Hospit			4b. City, Town, or		Death		4c.	County of Dea	
	Funeral	Г	5. Social Security Nu	umber 6. S	Sex 7. A	ge (In yrs. last	birthday)	Freder If Under 1 Year	If Under 2		3. Date of Birt	th	Freder	tholace (State or Foreign
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92	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Marrie	ed 2 🗆 Married	12. Was Decedent Armed Forces? 1 XYes 2		lf lf	/as Decedent of His Yes, specify Cubar	n, Mexican,	n? (Specif Puerto Ric	y Yes or No- can, etc.)		14. Race - Ame Black, Whit	
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Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature Fund	eral Service Licen	ee 0/2	10		Name and Address				_		The state of the s
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8760	tificate ng phy as the		IF FEMALE:		u									
Box 68	th cert ttendir or use	ian/	23b. Was decedent p in the past 12 me	a cyliani	23c. If yes, outcome 1 \sum Live Birth	2 Fetal de	eath 3 🗌	Ectopic pregnancy				2	3d. Date of deli	ivery
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P.0	that timed b	by P	Part II. Other signific	cant conditions co	entributing to death b	ut not resultin	ng in the un	derlying cause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
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Division of Vital Records, P.O.	al or Attending Physis after death. Il Director: After this ad in by the funeral d	Certificate:	4 Homicide	determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, stree	t, factory, office		28f.	Location (St. City or Town	reet and I , State)	Number or Rura	al Route Number,
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		-	For State Registrar	State of M	arylar		artment of F tificate of D			giene Reg. No.	010	32480
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Exar		r	4a. Facility Name (if not institution, given Holy Cross Hos					Location of Death	na		nty of Death	ery County
Funer Direct	_		5. Social Security Number 152-26-5564	Sex 7. Age XIX M 2 □ F	7 2	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th		place (State or Foreign ntry) NJ
aryland a-f show fied at		CIOL	Usual Residence of Decedent 10a. State 10b. County PG			y, Town or Loc						10d. Inside City Limits
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land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		<u>-</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.		If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	В	Race - Americal Americal Americal American Rack, White,	etc.
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Lotolar CO	naidillion	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)	Education	+)	(Give k life. DC	ent's Usual Occupa ind of work done di NOT use retired) Chef		ing	16b. Kind of	Business In	,
/land 2 d be filed w Mental Hygi arked other	5	8	17. Father's Name (First, Middle, Last) Walter Bra			<u> </u>		18. Mother's Nam	e (First, Middle, enia Da	Maiden Surna	me)	Lanc
											, State, Zip o MD 2	0770
Saltimore , bermit. Page 1 and Department of Hea mportant. If item any injury or othe			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	c	emetery, crem lantio	atory or other place C Crem	10/	Date 15/10		Bern	ie MD
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The law requires ate has been signage 2 should b	Completed								24a. Was a autops perfor 1 Yes	n 24b	. Were autor prior to con death?	osy findings available mpletion of cause of
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DIVISION Att	10	1	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.	(Specify)				28f. Location (St City or Town	, State)		
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C+	ate		Frederick D Mi. 1. Date filed (Month, Day, Year)	n 2101 Me	dica	al Pai	ck Dr #2	200 Silv	ver Spi	cing M	1D 20	902
Regist			OCT 18 2010	32. Registrar	J. y	parke						

10-07855 Mara Naomi Blank Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mara Naomi Blani		Si 1- For State Registrar	tate of Maryla		artment o ertificate o		d Mental		20 Reg. No.	0 32481		
Physiciar Medical Examin	n/	Decedent's Name (First, Midd MARA NAOM					-	2. Date of De Month October	Day Year	3. Time of Death 0812 hrs		
		4a. Facility Name (if not institution Northwest Hospital		mber)		4b. City, Town, or Randallstow			4c. County of Baltimore			
Funeral Director	- 1	5. Social Security Number 213 – 11 – 9246	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	+	Hrs. 8. Date of B	` 1	9. Birthplace (State or Foreign Country) MD		
daryland 28a-f show any 1 at once.	_	Usual Residence of Decedent 10a. State 10b. County MD BAL	TIMORE	10c. City	y, Town or Locat	ion BALTIMORE	<u> </u>			10d. Inside City Limits 1 Yes 2 No		
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er death with	Funeral	11. Marital Status 1 Never Married 2 N	larried Armed Fo	2XX No		as Decedent of His es, specify Cuban Yes 2 X No	, Mexican, Pue		White,	American Indian, Black, etc.		
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ore, MD 2: s: 1 and 2 should of Health and M If item 27 is m: her traumatic	-[19a. Informant's Name/Relations LILLIAN LURIE 20a. Method of Disposition			9 HU	RDLEFORD	COURT			State, Zip Code) 21209 City or Town, State		
Baltimore, MD permit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumant.		1 X Burial 2 Cremation 4 Donation 5 Other S		m State	ATZ CHAI	M CEMETER	RY 10)/15/2010	BALTIMOF	RE, MD		
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
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Box 68760, e death certificate be the attending physici ed for use as the buni	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Un	1 Live bi	outcome of pre- rth ant at time of d	gnancy 2 Fe	g 909 11/5 tal death 3 [her (Specify)	5 / 10 T1		23d. Date of d Month	elivery Day Year		
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f Vital Rec Physician: The l er this certificate l ral director, page	9 Re	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	Managhali —		ER/Outpatient	3 DOA	of Death (Che Other A Nu y at Work?	rsing Home 5	Residence 6	Other:		
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the best of the fineral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the fineral director, page 2 should be detached for use as the but the fineral director, page 2 should be detached for use as the but the fineral director, page 2 should be detached for use as the but the fineral director.	Certification:	1 Natural 5 Peninve 2 Accident Inve 3 Suicide 6 X Cou	ding stigation Fd 10	Day,Year) /13/10	Fd 7:2	_ 1□∨	es 2X No	unk	(Street and Number	or Rural Route Number, City Lane		
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F 3 F 8	ME	29b. Signature and title of certific				29c License O.C.M			29d. Date signed October 13,	(Month, Day, Year) 2010		
OV			sistant Medical E	xaminer	111 Penn S	Street, Baltimo	re, MD 212	201				
State Registra	~	31. Date filed (Month, Day, Year)	9 2010 32. Re	istrar's Signat	ture	-						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month October 13, 2010 6:05 AM /Medical Helen C. Clayton 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gaithersburg
| Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Montgomery Asbury Methodist Village 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🂢 F Yrs Feb 18, 95 1915 Washington DC Director 579-01-6314 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f sh Funeral Director 1 ☐ Yes 2√ No Gaithersburg MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20877 USA 333 Russell Avenue #419 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Evantion Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Be Completed by Specify: white 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare 12 nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie May Cornwell John Eston Smallwood ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Smallwood III/nephew 3221 Carroll Road Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 □ Other (Specify) 21. Signature of Eurieral Service Licensee State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Chri nary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rasyark Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specifical States) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely within 2 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ 04115 1 Va Dehert Duschba October 13,2010 201 RUSSELL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAITHERSBURG, MAD. 2087 31. Date filed (Month, Day, Year) 0CT 18 2010 2. Registrar's Sign tture State Registrar

Division of Vital Records, P.O. Box 68760

Physician/

Funeral

Director

than "natural", or items 23a or 28a-f sho e Medical Examiner must be notified at

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Director

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Id be I Menta arked	욘	Johnny Crawford	Sr				11 Foster		
shoul and is m		19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street	and Number or	Rural Route Numbe	r, City or Town, State,	Zip Code)
nd 2 sealth m 27		Linda Crawford/s	spouse	_ 501 [olphin S	Street #	1106 Bal	timore, MD	21217
of H of H if ite		20a. Method of Disposition 1 Burial 2 Cremation 3	206	. Place of Dispos	ition (Name of atory or other plac	20)	Date	20c. Location - City	or Town, State
Page tment tant: jury o		4 Donation 5 X Other (Specify	in state	cometery, crem	atory or other plat	.6)			
permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: if item 27 is marked other any injury or other traumatic event, the once.		21. Signature prieral Service License	1al	Ra	1 timore	MD 21	201	Baltimore	Street
		23a. Rart 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the de	eath. Do not ente	the mode of dyin	g, such as cardi	iac or respiratory ar	rest,	Approximate
Physician/		Immediate Cause (Final disease or condition	Dag. Co	+ 00	Non to	m . 011	0 : 4 :		Interval Between Onset and Death
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at the	Ė	Part II. Other significant conditions con	ntributing to death but not re	esulting in the un	derlying cause giv	ren in Part I.	23e Did to	bacco uno contributo	to the cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Chronic obstr	active Duly	MIMAG	disease	-asthi	na 10		Probably 4 Unknown
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ng F) <u>s</u> e	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		ow injury occurred	
eath. or: A	<u>≅</u>	2 Accident Investigation				Yes 2 No	1		
r Att ter d irect	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, stree	t, factory, office		28f. Location (S	treet and Number or R	Rural Route Number,
ital call rate at a la la la la la la la la la la la la l							City or Town	i, State)	
losb t hou uner	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examina	cian: To the best of my know	wledge, death oc	cured at the time,	date and place,	and due to the cau	se(s) and manner as s	stated.
he H lin 24 he F	ĕ.	only one) 3 Certifying Nurse	er: On the basis of examinati Practioner: To the best of r	on and/or investig ny knowledge, de	ation, in my opinion ath occurred at the	n, death occurred time, date and p	d at the time, date ar place, and due to the	nd place, and due to the cause(s) and manner a	e cause(s) and manner stated as stated.
Vaith To Con		29b. Signature and title of certifier		_	29c. License			29d. Date signed (Mon	
		Asshpreet Ka	war, MBB	5.	RES	>-000		October	
		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Pri	nt)				
	_	ARSHPREET KY	AUR, SIN	JAI HO	SPITAL	OF BA	LTI MORE	2401 W. BE	WEDERE AVE
State	9	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1			BALTIMOR	WEDERE AVE.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32484 State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Oct 13, 2010 Callaway Ralph 9:59 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Forestville 1905 Benson Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of bil... (Month, Day, Year) 1 1939 9. Birthplace (State or Foreign 8. Date of Birth Funeral 234 58 8626 1 XM 2 □ F 7Ó Months Davs Hours Min. Country) West Virginia Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Forestville 1 Yes 2 No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 1905 Benson Lane 20747 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No 1956
If Yes, Give 0 1 Never Married 2 X Married þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Manager Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mae Ellis Perry Lee Callaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Margaret Callaway (Wife) 1905 Benson Lane, Forestville, MD 20747 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Oct 18, 2010 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Sign tu f Funeral S <u> MOOQS 1</u> Ave, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 N **Division of Vital** Be B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) 1 Tyes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar andar, MD, 6001

andover Road, Cheverly

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

enkataraman

Registrar

DHMH 17 Rev 1/2001

State

29b Signature and title of certifie

Patricia Aronica-Pollak MD

30. Name and address of person who completed cause of death (Item 23a)

OCME

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 13, 2010

Assistant Medical Examiner

32. Registrar's Signature

escen

Registrar DHMH 17 Rev 7/2009

State

MSRAJUPAMEM.D

31. Date filed (Month, Day

182010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

N-S. Rajapakse, M.O.

Division of Vital Records, P.O. Box 68760

28355min

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10/13/10

Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anne E. Englar Medical 2010 5:45pOctober 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Baltimore Center 7. Age (In yrs. last birthday) 8. Date of Birth Aug 15, Year) 921 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Months Days Hours 89 Mary Tand Director 215-14-6630 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 400 Georgia Court #128 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Englar Anne Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bookkeeper financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul W. Englar Anna Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2518B Montgomery Street Laure1, MD 20707 Barbara Scott/niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Signature Funeral Service Licensee State and Address of Each board 655 W. Baltimore Street Director MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death RESPIRATORY Physician/ Medical ue to (or as a consequence of) Examiner EGIONAIRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?
1 Yes 2 No ò Month ed by the a g Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No 2 Other: 1 💢 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital To the Hospital within 24 hours To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed

State Registrar DHMH 17 Rev 7/2009

182010

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

ause of death (Item 23a) (Type, Print)

Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ 32488 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ENGRAH Physician/ ARTHUR 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SILVER SPRING HONTGUMER HOLY CROSS HOSPITAL 6. Sex 1 M 2 U If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) WASH, D.C. Month, Day, Year 944 7-58-499 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director WASHINGTON DC. 1 Yes 2 No 10f, Zip Code 10e, Street and Number 10g. Citizen of What Country? STREET Funeral 2000 2 529 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BUACK If Yes, Give Year or Dates, 8165 - 867 3 🗆 Widowed 4 💢 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) BUS OPERATUR College (1-4 or 5+) EIVATE Elementary/Seconday (0-12) Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hethur L. ENGRAM, SR ENGRAM HARRIGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denunter 3207 Beaumont St. Temple Hills, 40 Dionne Eugroum 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date TRIANGLE, VA 10-14-10 Antico NATIONAL CUM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
BIPNICH BY UPSHUR ST N.W. WASH, DC BIANCHI 110006 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 'eve bro vascular Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) as been signed by the attending physician and 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seizure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown mellitus Diabetes 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 0052586

State Registrar

5

1500 Furest Glen ROMO

silver Spring, MD 20910-1484

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATEL

			P	ease	Type or Pr								egible.	
			For 1 _ State		State of M	larylan	•	artment of I		and Me		0 /		32489
			Registrar				Cer	tificate of L	Jeatn			leg. Na.	0 0	
П	Physicia	in/	Decedent's Name (First, N		James 1	e a a l	_				2. Date of Dear Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not instit			cayı		4b. City, Town, o	r Location		oct.	15 4c, Cou	2010 unty of Deat	
-	, Examin	lei	Carroll			nter			tmin				Carro	
	Funeral		5. Social Security Number	6. Se		ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under	24 Hrs.	8. Date of Birth (Month, Day		9. Birt	thplace (State or Foreign untry)
	Director		212-40-3633 Usual Residence of Deceder		24.22.	67	Yrs.				04/18/	<u> 1943</u>		MD
	and show	ō	10a. State 10b. Co			10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl 28a-f ptifiec	Director	MD Ca	rrol	1		West	minster						1 🗆 Yes 2 💆 No
	h the	al D	10e. Street and Number					10f. Zip Code				_	of What Co	untry?
	th wit	Funeral	932 Hughes	Shop	Road 12. Was Decedent	Ever in LLS	2 13 1	2115 Was Decedent of H		igin? (Speci	fy Yes or No-	USA	Race - Ame	rican Indian
(0	or ite	y F	11. Marital Status 1 ☐ Never Married 2	Married	Armed Forces		'	f Yes, specify Cuba	an, Mexica	n, Puerto Ri	can, etc.)		Black, White	
93	within 72 hours after death with the Maryland giene er than "natural", or items 23a or 28a-f sho er than "dical Examiner must be notified at	Completed by	3 Widowed 4 Dive	` !	If Yes, Give Year or Dates.		1	I□ Yes 2 No	Specify	:		Spe	cify: Wh	nite
5-0	"2 hou "natu	plet		edent's Ed nighest gra	ducation ade completed)		(Give I	dent's Usual Occup kind of work done	during mos	st of working	,	16b. Kind o	of Business	Industry
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/lar	d be f Venta arked	ဥ	James	Eag	le					Eva	Davis			
Maryland 21215-0036	should be filed within and Mental Hygiene. Is marked other tha raumatic event, the N		19a. Informant's Name/Rela					ng Address (Street						
	and 2 s Health tem 27 i		Joyce Eagl 20a. Method of Disposition	<u>e-Wi</u>	fe	20h E		Hughes sition (Name of	Shop	Road				ID 21158 Town, State
Jor	Page 1 ment of I ant: If its ury or of		1 Burial 2 Crema	tion 3 🗆	Removal from State	e C	emetery, cren	natory or other plac					_	
Baltimore,			4 Donation 5 Ott			So		arroll (eld,MD
B	permit Depar Impor any in		1				2	54 East	Mai	n St	etcher . West	mins	eraı ter,M	номе ID 21157
			23a. Part 1. Enter the diseas shock, or heart failure.	a, or comp ist only or	olications that cause	ed the deat ne.	h. Do not ente	er the mode of dyin	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
2	Physician/		Immediate Cause (Final disease or condition		Non-si	mall	Cell	Lung C	ance	r				Onset and Death 2 yrs
المراب	Medical Examiner		resulting in death)	ſ	Due to (or as	a consequ	uence of):							
		Jer	Sequentially list conditions, if any, leading to immediate	J	b. Due to (or as	a consequ	uence of):							
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	be executed sician and burial-transit	al Ex	resulting in death) Last		Due to (or as	a consequ	uence of):							
09	or Attending Physician: The law requires that the death certificate be biter death. Diffector: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the but in by the funeral director, page 2 should be detached for use as the but in by the funeral director, page 2 should be detached for use as the but in by the funeral director, page 2 should be detached for use as the but in by the funeral director, page 2 should be detached for use as the but in by the funeral director, but in the funeral director, but in the funeral director is a should be detached for use as the but in by the funeral director, but in the funeral director is a should be detached for use as the but in the funeral director.	dice		•	d									
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Box 68760	eath certificate be attending physic ifor use as the bi	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		1 ☐ Live Birth 4 ☐ Pregnant	2 Feta at time of a	al death 3	Ectopic pregnand Other (specify)	cy			200.	Month	Day Year
. B	t the dea by the a tached	Physician/Medic	g 🗌 Unknown		g ∐ Unknown						1			
P.O.	res that signed to d be det		Part II. Other significant cor	ditions co	ontributing to death	but not res	sulting in the u	nderlying cause gi	ven in Part	1.				the cause of death?
rds	require been si should I	ted												robably 4 Unknown
000	has b	Completed by									24a. Was a autops	sy	4b. Were aut prior to o death?	topsy findings available completion of cause of
R	sician: The law of certificate has be irector, page 2 s		25. Was case referred to med	ical				26 PI	lace of Des	ath (Check o	1 🗆 Yes	2 No	1 🗌 Yes	3 2 No
/ita	s certi	To Be	examiner?	_	Hospital:	tient 2	ER/Outpatier	LOH	er.	,	e 5 🗆 Reside		Other (Spec	ifv)
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ion	tendir leath. or: Af the fu	ifica	2 Accident In	estigation ould not be				M 1 🗆	Yes 2					
Division of Vital Records,	or Att after d Direct in by	Certificate:		termined	28e. Place of In building, e	jury - At ho tc. <i>(Specify</i>	ome, farm, stre	eet, factory, office		28	3f. Location (St City or Town		mber or Rui	ral Route Number,
Q	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	ical	29a. Certifier 1 Certi	ying Phys	sician: To the best o	f my know	ledge, death of	occured at the time	e, date and	place, and	due to the cau	se(s) and ma	anner as sta	ited.
	ne Ho	Medical	(Check 2 Medi	eal Examin	ner: On the basis of se Practioner: To the	examination	n and/or invest	tigation, in my opinio	on, death o	ccurred at the	ne time, date an	d place, and	due to the o	cause(s) and manner state
	vithi To the	_	29b. Signature and title of ce	tifier		1	^	29c. Licens			2		ned (Month	
			June	2/) nuy	774	٢	K	1151	+		10.	15 - 1	0
			30. Name and address of per		•	,			na 38-	1	. 4			
	Sta	te	Simone Bra 31. Date filed (Month, Day, Ye	ar)	32. Regist	rar's Signa	ture .	tminste	r,Ma	тұтал	10			
	Registra		OCT	1820	010 Sens	un	B. A	racke	_		·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month UVER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NIER BALTIMOR 92TIMURE If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
Aug 21, 1955 6. Sex If Under 7. Age (In yrs. last birthday) Year **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 😾 F Months Days **Director** Yrs Mary Tand 215-70-0986 Usual Residence of Decedent show at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f si notified 1 Yes 2 □ No Baltimore MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? USA ems 23a or Funeral 21228 801 Winters Lane #114 items ? 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter idical Examiner Armed Forces? Black, White, etc. þ Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white Completed 3 Divorced 4 Divorced Specify: the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Cleda May Wells ပ Kenneth Harvey Lauver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1557 Barrett Road Baltimore, MD 21207 Richard Fauver/brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Funeral Sey ice Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. HEPATIC ADENOCARCINEMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence on. the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Year Pregnant at time of death Dav signed by the ar 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contrib*u*ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FDIUPATHIC THROM BOCYTIC PUR PUPA Completed 1 Yes 2 No 3 Probably 4 Unknown OBSTEUCTIVE PULMINARY PISERS. 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? certificate MOUITUS 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: မ 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA I Director: After this d in by the funeral dir 5 Residence 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🔲 Yes 2 🗌 No Accident Investigation To unc. within 24 hours a... To the Funeral Director: "~*ad filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name

nd address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Khardiatou Golok	1- For State Certificate of Death												
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle, Khardiatou		.oko					2	Date of Dea Month October		ar	3. Time of Death 0628 hrs
F 1200		4a. Facility Name (if not institution, Fort Smallwood Road a	_			1	y, Town, o	r Location of I	Death	October	4c. County of		
Funeral Director		5. Social Security Number 505_53_6571	. Sex	7. Age (In y	rs. last birthday) If U	nder 1 Yea		24Hrs. Min.	8. Date of B			thplace (State or in West untry) Africa
ń u		Usual Residence of Decedent 10a. State 10b. County	M 2		City, Town or Lo	Yrs.	l						10d. Inside City Limits
ne Maryland or 28a-f show any fied at once.	ģ	MD	N/A		,,	Ва	ltimo	re					1 Yes 2 No
h the Mar 3a or 28a otified at	Director	10e. Street and Number 1318 Divisi	on Street	:		101.	Zip Code	21217			10g. Citizen of Wh		rica
	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor	ied 12. Was Dece Armed For 1 Yes If Yes, Give Year or Dates:	ces?		If Yes, spe	ecify Cuba	spanic Origin n, Mexican, P o <i>specify:</i>			0- 14. Race White Specify:	e, etc.	can Indian, Black,
036 ithin 72 hours ne. r than "natur fedical Exami	Completed t	15. Decedent's Education (Specific Elementary/Secondary (0-12)	conly highest grade College (1-			most of v	vorking life	ition (Give kin b. DO NOT us lorker			16b. Kind of Bu		ndustry NOUSE
21215-0036 Mental Hygiene Marked other than event, the Medica	& &		Goloko						Name (F Rami		Maiden Surname) Kane		
MD 2. d 2 should lth and Mc n 27 is ms aumatic er	Ī	19a. Informant's Name/Relationship Yero Lam	(Type, Print)		Unk						mber, City or Tow		
도 수 필 등 등 4 Donation 5 Other Specify:											W. Africa		
	-	21 Signature of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the build of the detached for use as the build detached for the property of the funeral director.		IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno		th nt at time of	2	Fetal deat		Ectopic pr	regnanc	у	23d. Date of a Month		ay Year
P.O. Fres that the signed by the detached	≥	Part II. Other significant condition	s contributing to d	death but no	ot resulting in th	a underlyi	ng cause g	given in Part I.			obacco use contrib		he cause of death?
Division of Vital Records, tal or Attending Physician: The law requirer as after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be designed.	Completed								_	24a. Was autop perfo 1 Yes	osy pr rmed? de		opsy findings available ompletion of cause of S 2 No
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Division To the Hospital or Attendi within 24 hours after death, wither Puneral Director: , completely filled in by the fill	` 1 ⊢	3 Suicide 6 Could n 4 Homicide determin	ot be led (Specify)	Major Ro	t home, farm, st pad / Highwa	ay			Fo	or Town, S rt Smallwoo	itate) od Rd at Kembo	Rd, C	
ithin 24 l	<u> </u>	29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of er:On the basis of and manner stat	examination									
F SF 3	ž [9b. Signature and title of certifier	· P	00 4	- 4	2	9c. Licens				29d. Date signe October 13,		th, Day, Year)
2v		00. Name and address of person whe Patricia Aronica-Pollak M			em 23a) al Examiner	111	Penn St	reet, Baltir	more,	MD 2120	1		
Stat Registra		11. Date filed (Month, Day, Year)	32. Regi	strár's Sign	ature					-			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Mary S. Hobbs October 6 1:00 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) June 16, 1 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 X F 212-74-3448 Months Days Hours Min. **Director** 1957 Washington DC Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State Director 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified MD Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3207 Woodside Avenue USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 education teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barbara Ann Hagadorn Edward Francis Seibert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Hobbs/spouse 3207 Woodside Avenue Parkville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronald S Warts 22. Name and Address of Facility State Anatomy Board 655 W. BAltimore Street Director 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause) Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Cther (specify) ___ Pregnant at time of death Month Day signed by the a Id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Completed plnous 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate performe Yes 2 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manuter of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Year) 18

2010

Day,

Date filed (Month

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32493 Certificate of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1660R Medical OPTEMBER 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 27/more 8. Date of Birth Oct 25, 1922 6. Sex If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 💢 F Months 475-18-0318 Wisconsin Vrs **Director** 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural" or an any injury or other trainmetric. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 103 Center Place **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amelia Eulalie Izabel Parent Geroge William Conners 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen A. Harris/daughter 800 Mace Avenue Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature Funeral Servir e Licensee State Action & Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ RONA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day Year Unknown 9 Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OMYOPATH Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 - No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	te of Maryland	aryland / Department of Health and N Certificate of Death			2010 32191		
	Physicia	n/	Decedent's Name (First, Middle, Last)	/	/			2. Date of Death 3. Time of Death		
,	Medi Examir	cal	4a. Facility Name (if not institution, give street an	d number)	4b. City, Town, or Location of Death			Month Day Year 08/5 4 M 4c. County of Death		
	r		Baltimore VA Medica	Center		Baltim	0/0		4c. County C	
	Funeral Director		212-34-1736 6. Sex	7. Age (In yrs. last)	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 01-17-	h 1939	Birthplace (State or Foreign Country) MD
	land show dat	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	cation				10d. Inside City Limits
	e Maryl r 28a-f notifie		MD	E	BALTIMORE				1 👿 Yes 2 □ No	
	e filed within 72 hours after death with the Maryland Ital Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral [3712 FERNDALE AVENUE			10f. Zip Code 212	07		10g. Citizen of W	hat Country?
21215-0036			11. Marital Status 12. Was	Decedent Ever in U.S. ed Forces? Yes 2 ANo	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc.
		ted by	2 YWidowed 4 Diversed If Ye	Yes 2 ♣No s, Give or Dates.	1	Yes 2 No	Specify:		Specific	BLACK
15-(Completed	15. Decedent's Education (Specify only highest grade comp.	leted)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of worki	ng	16b. Kind of Bus	
212		To Be	12	ge (1-4 or 5+)		ALURGIST			BETHLEE	IEM STEEL
Maryland	ould be filed d Mental Hy marked oth matic event		17. Father's Name (First, Middle, Last) JAMES A. HOWARD				18. Mother's Name		Maiden Sumame)	
Mary	Page 1 and 2 shonent of Health an ant: If item 27 is ant: or other trau		19a. Informant's Name/Relationship (Type, Print)	1	19b. Mailin	g Address (Street a			; City or Town, Sta	ate, Zip Code)
			YVONNE L. PAYNE/SISTER 20a. Method of Disposition	20b. Place		HAYWARD sition (Name of		BALTIM	ORE, MD	21215
Baltimore,			1 ☐ Burial 2 😿 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State ceme	etery, crem	atory or other place	e) <u>i</u>	16-10		Oity or Town, State ORE, MARYLAND
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	In ton					ORTON &	SONS F.H., INC.
		ledical Examiner	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of	that caused the death. Do		701-31 Lar the mode of dying			TIMORE, M	Approximate
-	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Aight Failure Due to (or as a consequence of): Sequentially list exhibitions.							
	Examiner		Sequentially list our difference, b.	to (or as a consequence	ce of):	Thombus				1 Month
7	ed sit		if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	e to (or as a consequenc	consequence of):					
	cate be executed physician and sthe burial-transii		that initiated events c	e to (or as a consequenc						
200	sath certificate be executed attending physician and for use as the burial-transit		d							_
89 ×		an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes	s, outcome of pregnancy Live Birth 2 Fetal de	ath 3 🗀	Ectopic pregnancy			23d. Date	of delivery
Box	he deat y the at iched fo	Physician/M	1 Yes 2 No 4	Pregnant at time of death Unknown	h 5 □	Other (specify)			Mont	h Day Year
Division of Vital Records, P.O.	Inysician: The law requires the his certificate has been signed alrector, page 2 should be discounted by the control of the co	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
ords.		leted								
Heck		Completed				<u>.</u>		24a. Was a autops perform	med? prid	ere autopsy findings available or to completion of cause of ath?
<u> </u>		a l	25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No							
o †		te: To	27. Manner of Death 28a. [1 ☑ Inpatient 2 ☐ ER/0 Date of injury 28b Month, Day, Year)	. Time of	28c. Injury a	4 ☐ Nursing Hon		ence 6 Other ((Specify)
Slon	death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		injury		es 2 No			
	tal or A rs after al Direct ed in by								or Rural Route Number,	
	within 24 hour To the Funer completed fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
			29b. Signature and title of certifier 29c. License number 2					29d. Date signed (Month, Day, Year)		
		}	30. Name and address of person who completed	cause of death (Item 23a)) (Type, Pri	152 July 1	7 2/		9/13/	2010
			Esteban Gullego 27 So 31. Date filed (Month, Day, Year)	ruth Grane	5+.	Baltimore	MD C	1051		
	State Registrar St. Name and address of parts of which completed dates of death (tem 23a) (type, Print) Esteban Gulliso 27 South Greene St. Baltimore MD 7/701 31. Date filed (Month, Day, Year) OCT 18 2010 Senting S. Barkel									

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) State

neria

tarrell-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8710 Empered Boutimore, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16a Per FH G908 1/18/10 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 14, Day 2010 Year Alverta S. Jones 11:20 aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner FutureCare Cherrywood Reisterstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 297-20-1855 1 M 2 M 2 89 Hours June 14,1921 Director Vrs Maryland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Reisterstown 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12020 Reisterstown Rd. 21136 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Lifensical use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 12 Lincensed Pratical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mamie Littleton Branson ည John Clark 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number of Bural Route Number City or Town, State, Zip Code) 3630 Coronado Rd., Windsor Mill, Md. 21244 James Eley Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct. 19, 2010 Owings Mills, 2Md Md. Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat e of Fu eral Service Li 22 Name and Address of Facility Chapel, P.A. 11605 Reisterstown Rd., Owings Mills Md. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONFEITIVE Physician HEAMT PAILUNE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte Day Year 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifier 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (WICEXIME MICE

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 4A-C, PER NP G931 9/26/12 TRT Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Tannous S. Khalil October 2010 Medical PRINCE GEORGE'S Examiner Facility Name (if not institution, give street : RENATSSANCE GARDENS 4b. City. Jown, or Location of Death SILVER SPRING Social Security Number 7. Age (In vrs. last birthday If Under 1 Year 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Months Days Hours Min (Month, Day, Yea Eb 14, 1 Director 215-38-6759 83 FEb Lebanon Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 Yes 2 No MD Montgomery Silver Spring 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 3148 Gracefield Road CL-408 20904 items filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iter edical Examiner 14. Race - American Indian, Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ 2 X No Maryland 21215-0036 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Specify: Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ 12 scientist food industry Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Heatth and Mental I Important: If Item 27 is marked o any injury or other traumatic eve Sirhal Tannous Khalil Alice Derien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3148\ Gracefield\ Road\ CL-408\ Silver\ Spring,$ Edna Khalil/spouse MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signalure Funeral Serice Licensee State Anatomy Board 655 W. Baltimore Street MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) pulmonary embolism month Medical Due to (or as a consequence of) Examiner atrial fibrillation 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown his certificate has been signed by the director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, cerebral vascular accident Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of personcwho completed cause of death (Item 23a) (Type, Print) Eileen GEmmell 3110 Gracefield Road Silver Spring, MD 20904 32. Registrar's Sig State Registrar

amend Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 15,16a&b&19a&b Per ANA BD G908 10/18/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monthy CTOBER CLU PM Rivka Kaestner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Months Days Hou*rs* Min Month Day, Ye Director 69 Yrs 1940 219-40-0555 Usual Residence of Decedent 28a-f show 10a. State 10b. County after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 339 Homeland South Way 21212 USA unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married unk þ If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: White Completed 3 Widowed 4 Divorced is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business Industry unk life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 12 0 Nurse **Healthcare** Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 0 ^{19a.} Mary's Pathicip Smith Good Samaritan Hospital 1**942** all **Hometand** a **Southway** a Rou**batteinist do Mo** at **1212** and 1841 times and 1842 and 1842 and 1843 and 1844 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in . Signature of Funeral Solvice Licens ... State Anatomy Board 655 W. Baltimore Street Director Raltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Typeardie Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day cate has been signed by the a page 2 should be detached it g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? death? ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide within 24 hours after death To the Funeral Director: A 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 058570 29d. Date signed (Month, Day, Year)
Octuber 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrance L. Balks 40 5601 Loch River Blud Balts crance park 31. Date filed (Month, Day, Year) State . Registrar's Signature OCT 182010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manthibe 11:53 AM Krebs 4 2010 Medical 4b. City, 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Baltimore Washin Leauca (ente Glen Burnie Anne 5. Social Security Number Age (In yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗵 F Months Hours FEBRUARY TS 34 76 Director 215-30-1264 MD Usual Residence of Decedent show or 28a-f shov notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 🔯 No Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene.

The more after a principle and the marked other than "natural", or items 23a or more any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 21122 8418 Maryland Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify. Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Krebs Rosinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Krebs, Sr. 8418 Maryland Road, Pasadena, MD 21122 (spouse Date 18 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Metro Baltimore, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the di Approximate Interval Between Onset and Death ase, or complication shock, or heart failur Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNO 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28c. Injury at work?
1 Yes 2 No Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural injury 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Registrar

32. Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 20b, c per in g908 10-18-10 vt.

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Vilyam Knopt 6:301 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1√√M 2 □ F Months Days Hours Min. Country) UKRAINE 0290691925 214-37-9504 85 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2 X No BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral UKRAINE 21209 5 SUNTOP COURT, UNIT 102 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the SHIPPING ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental. Important: If item 27 is marrany injury or other: and Mental I is marked o ပ VITALIA RIMALOVA KNOPF MOSES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUNTOP COURT, UNIT 102, BALTIMORE, MD LYUDMILA KNOPF/WIFE 20c. Location - City or Town, State **Baltimore REISTERSTOWN**, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date Driften Redigo or other place)
BALTIMORE HEBREW CEM. 10/17/2010 1 X Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., In he 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic prostate cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician as the burial-t Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ō Month Day Year Pregnant at time of death Unknown 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ج</u> 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed page Hospital or Attending Physician: The 2 🗌 No 1 🗌 Yes 2[Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After missing the function of the function o 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ty Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the desired of the cause (s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MS Rujupahse M.D 10/14/10 DUUS7 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. S. Rajapakse, M.D. 2835 Smith Av. S. 203, Baltimore, M.D. 21209 N. S. Rajapakse, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar